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Original Article.

REMARKS ON THE TREATMENT OF ROSE-COLD AND HAY FEVER BY COCAINE.*

BY J. M. DA COSTA, M.D.,

Professor of Medicine in the Jefferson Medical College, Philadelphia.

In a communication which I made to the College last December,† I suggested that cocaine ought to be advantageous in hay fever. During the past summer I have had several opportunities of carrying this thought into effect, and, as I see by some very recent journals, others, too, have employed the drug with the same purpose; altogether, I think, it has been sufficiently tested for us to welcome it as a very decided addition to our means of counteracting this most troublesome affection.

The first case in which I became familiar with its use was one of great susceptibility of the nasal mucous membrane, which I saw last spring in a Southern gentleman. It was more like rose-cold, strictly speaking, than like hay fever, but due to the same irritability of the mucous membrane, and always marked and most annoying with early vegetation. A two per cent. solution, which I afterward increased for a time to a four per cent. solution, gave him such comfort and relief, that I had some difficulty in inducing him to discontinue the remedy. He said that its local employ not only soothed the intolerable irritation and stopped the sneezing fits, but exerted a quieting influence over his whole nervous system, similar to what he experienced from small doses of morphia, to the influence of which he was very sensitive.

One of the most striking instances of success I had with cocaine was in a young lady who had been for four years a great sufferer from rose-cold, which always came on about the middle of May, and lasted until June. Later it became a hay fever, and attacks of troublesome asthma complicated the disorder during the summer and early autumn, especially in the latter part of July and August. She is a young lady with a sound digestion, and calm nervous system. It has been her habit to leave her country home in summer to go to Newport, whence generally, after a month's struggle with asthma, she has been obliged to move to some of the hay fever resorts in the White Mountains. Her eyes and nose suffer much in the earlier stages of the complaint; there is, however, no sore throat. Later a bronchial affection and asthma appear. The main complaint in the earlier stages is from the intolerable sneezing. This occurs especially in paroxysms in the morning, and is apt to stop after breakfast, although on cool days it often continues all day long. There is, also, especially under such circumstances, much running from the nose. All her pleasures have been interfered with, and her life in summer rendered very miserable by the complaint. She had tried many remedies, both local and general, without effect. Late in May I prescribed cocaine for her, a four per cent. solution, telling her if she had any throat irritation to apply the remedy also to the throat. This she did not find necessary, the cocaine injected every morning into the nostrils by means of a medicine dropper, about five drops in each nostril, gave her prompt relief. It arrested at once the sneezing fits, and she was comfortable, even free from coryza, all day. Once in a while, especially on cool days, a second application in the afternoon was resorted to, but this was rarely required. The numbness from the application lasted about fifteen minutes, and she perceived it more in the throat than in the nose. The most gratifying result from the use of the remedy was, that it prevented the asthmatic seizures.

She passed her summer at Newport without discomfort, only employing the cocaine after a time occasionally, and as she thonght she needed it.

The cocaine employed in these and other cases was a four per cent. solution. A weaker solution, I am convinced,

*Read before the College of Physicians of Philadelphia. Stated Meeting held October 7, 1885. The President, J. M. Da Costa, in the chair.

†Published in the *Med. News* of December 13, 1884.

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rarely does good. A stronger solution may be found necessary, and, before abandoning the remedy as ineffectual, I should always advise an eight per cent. solution to be tried.

In one case in which I applied a four per cent. solution, cocaine had previously been used, but, I have reason to think, in a much weaker form. The patient, his physician told me, had had hay fever most violently for fifteen years. He was known all over the West as "the hay fever man." He had tried everything; cocaine, too, had failed to relieve him. The attack came on always on the 17th of July, and lasted, with great severity, for months; some bronchial catarrh, but very little asthma accompanying it. On the 26th of September he tried a four per cent. solution in the evening, and slept that night comfortably for the first time for months. He has since used from five to eight drops, thrown up the nostrils with a medicine dropper every evening, and always with the best results. He does not like to resort to it in the daytime, because he finds that the fluid passes down his throat, benumbs it, and makes his speech difficult.

Other than the effect just mentioned, I have not seen any unpleasant result from its use. I must, however, except the case of a young married lady, who found so much relief to her hay fever from the local use of a four per cent. solution, that she employed it a number of times daily. The consequences were increased vascular tension and violent and distressing headache.

There is, undoubtedly, an insusceptibility—in some a varying susceptibility—to cocaine locally used. Thus, in an elderly lady with rose-cold, in whom no local remedies act speedily, a four per cent. solution produced very little impression. I meant to try an eight per cent. solution, but, as she left the city, I had no chance, and am thus forced to record this case as a failure.

The manner of employing the cocaine is not without importance. It may be used with a small atomizer as a spray. But the readiest means is to inject from five to eight drops up each nostril, the head being thrown backwards; in some persons once, in most, twice daily, will be found sufficient. It will be necessary to instruct patients not to irritate the membrane by rubbing it needlessly with the glass tube, or pushing this up too far. Thus a patient who had fever for thirteen years, and who was at the seashore on the 17th of August when the hay fever came on, and in whom tincture of ignatia amara seemed favorably to influence its course, tried cocaine in one nostril only. He inserted the tube far up, irritated the membrane, and water ran from that nostril, which became sorer and more inflamed than the other. More judicious attempts produced better results, but he could not be persuaded to give the remedy a fair trial, owing to his first experience with it.

Its mode of action in hay fever is partly by the local insensibility it produces, partly by the contractions of the capillaries it induces. The effects are thus chiefly local. It will not arrest the bronchial catarrh or the asthma, which attend some cases; yet it is astonishing how it seems to lessen the tendency to these complications when early applied, aud before they have got much headway. Is its action, then, not partly a reflex action? That the remedy is radical, and, strictly speaking, curative, I have not found; but that it gives great comfort, converts bad into light cases, enables those to stay at their homes who otherwise are obliged to flee to hay fever resorts, relieves much suffering and distress, I know and have fairly tested. In no case of rose-cold or hay fever ought cocaine to be left untried.

[After the reading of the preceding paper:—]

Dr. Harrison Allen remarked: I am glad to hear Dr. DaCosta state that the effect of cocaine is inconstant within a narrow range in different individuals. I have observed the same fact. In endeavoring to account for it, I have concluded that the difference lies in peculiarity of the erectile tissue. Those persons in whom the tissue is sparsely developed are, I think, less susceptible to impression by the remedy than are those in

whom it is well developed. I recall one case in which a four (as well as an eight) per cent. solution was used persistently without benefit. If, then, one has under observation nasal chambers with mucous membrane exhibiting but little erectile property (changing very little under any of the conditions, such as galvanism, which ordinarily constrict the capillary network), the remedy will give but little relief. I have had three such cases under care during the past summer. The shrinking up of the erectile masses places the nose in what may be called a normal condition, the air passing through at a normal rate and the irritated surfaces not touching each other. One of the cases in which relief was not secured, was that of a lady suffering from the annoyance due to complete occlusion. After applying the cocaine for half an hour there seemed to be a little relief, but it lasted only a short time. Notwithstanding these failures I have no doubt that further experience will show the truth of the author's statement, that we have in cocaine a remedy which will, in the majority of cases, give relief.

Dr. H. C. Wood said: In this connection, the observations of Dr. Lyons, of Detroit, may of interest. He has shown that there are probably two or three alkaloids in cocoa leaf, and that the commercial alkaloid, cocaine, not rarely is composed of more than one alkaloid, ecgonine, and perhaps a third alkaloid is present. The unexpected results sometimes obtained from the therapeutic use of cocaine, may possibly be due to the presence of these or other alkaloids.

The Chairman, Dr. Ruschenberger, asked: Can any one tell us whether or not caffeine is capable of taking the place of cocaine?

Dr. H. C. Wood: I have made some experiments with caffeine on the eyes of patients, and found it to be without effect.

The Chair of Histology at the Faculty of Medicine, left vacant by Prof. Robin's death, will probably be disputed by numerous candidates, among whom the most prominent are Drs. Lancereaux and Mathias Duval and Professor Ranvier.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD OCT. 16, 1885.

The 163rd meeting of the Clinical Society of Maryland was called to order by the President at 8.30 P. M., at their new hall, corner of Saratoga and St. Paul Sts. After reading of minutes the following gentlemen were proposed for membership: Dr. Dr. Geo. L. Staley, Dr. Geo. Thomas and Dr. Fayette Latham.

Dr. Christopher Johnston, Jr., brought before the Society

A PROSTATIC CATHETER

made at the suggestion of Dr. Christopher Johnston, Sr. The instrument wa peculiar in having a wedge-shaped point with lateral openings. The wedge assisted its passage through the prostate, while the lateral openings facilitated the drainage of the bladder. At the distal extremity this instrument was curved anteriorly for about ⅓ its length, to an angle of about 45°, the curvature being claimed to assist the patient in introducing it himself while in the erect position.

Dr. Tiffany exhibited

AN OSTEO-SARCOMA FROM THE HEAD OF FIBULA.

Eight months ago an enlargement appeared, and after a variety of treatment was finally incised, with the escape of a milky and bloody-looking fluid. In making the incision the external popliteal nerve was severed, for immediately the foot dropped, paralyzed, the patient complaining of a sensation "as if the foot was being torn from the limb." No *general* glandular enlargement was present, but in the popliteal space and over the saphenous opening the glands were found to be hard and swollen. The growth was removed by amputation through the lower third of the femur. The wound was dressed with iodoform and oakum, with cotton externally, and was not uncovered for eight days. It is

now ten days since the operation was done and the patient is doing well. The growth is probably of periosteal origin.

Dr. Tiffany also exhibited

A SLOW GROWING TUMOR

removed from the right carotid region of a negress of about middle age. It was deeply adherent and crossed the median line for a distance of about two inches. The growth was probably fibro-cartilaginous.

Dr. Chambers thought it of interest that the osteo-sarcoma should have occurred at the head of the fibula instead of the head of the tibia, as is most frequently the case.

Dr. Branham was desirous of knowing the treatment of the gland over the saphenous opening.

Dr. Tiffany thought best to leave it alone as these glands often resolve after removal of the primary cause for irritation. He thought them more frequently the result of irritation than of a specific deposit, because of the fact that sarcoma so rarely disseminates through the lymphatics. He related several instances where the glandular enlargement disappeared after the removal of the tumor.

Dr. Branham asked for the histological character of the tumor, for, he said, if it was of the small round cell variety, then almost surely was the glandular swelling due to deposit from the primary tumor. It was his opinion that the gland should have been removed.

Dr. Keirle has seen secondarily enlarged glands disappear after removal of the primary tumor.

Dr. Keirle exhibited

THE INTESTINES FROM TWO CASES OF INTUSSUSCEPTION.

One was the telescoping of ilium into ilium. The other was of ilium into cæcum. The latter, he thought, could not have been relieved. The former, in his opinion, might have been cured. He thought that where vomiting, with tumor and pain in the abdomen were present, you were safe in diagnosing intussusception, providing a bloody and mucous diarrhœa should set in—the latter symptom, he thought, should clinch the diagnosis. When gangrene occurs, it is late, and is a conservative process of nature. Incoördination of muscular action, he thinks, is the cause of these troubles.

He quoted a number of valuable statistics on the subject.

The chances of saving the patient are in proportion to the promptness of operation.

Dr. Woods quoted Da Costa as saying that "when the obstruction is high up, the urine is diminished, and when low down it was increased or normal." Had any member ever noticed this condition? If true, he thought it a point of considerable diagnostic value.

Dr. Earl thought the urinary phenomena due to shock; for the higher up the obstruction the greater the shock, and the greater the shock the more diminished would the excretion of urine become.

Dr. Chambers, who treated one of the cases related by Dr. Keirle, said that no positive diagnosis had been made, although the condition had been suspected. Little or no change in the urine was noticed. Did not agree with Dr. Earl's theory for the change in the amount of urine, but thought that when diminution in urine was noticed that it was due to loss of fluids by constant vomiting. He has serious doubt as to the accuracy in diagnosis in many of these cases reported cured by the ordinary means. Don't believe in the mechanical treatment for relief by injections of water.

Dr. Keirle thought that where ilium was intussuscepted into ilium, that relief might be given by pressure brought about by distending the cæcum with water, in this way causing an artificial kneading.

Dr. Tiffany said as to the question, "Could substances be forced from the great into the small intestine through the ilio-cæcal valve" that no general statement could be made. He had done many experiments with a view of settling this point, but found it impossible to do so, because of the great difference in the anatomical structure of the valve in different people. He had injected water and air, and while the results were very variable yet he *thought* that he got *air*

though more frequently. He had never tried substances of the consistency of fæces. The valve is normally formed by a slight degree of intussusception of the ilium into cæcum and one can readily conceive how this condition of invagination could be increased by any incoördination of muscular contraction. In operating, it was his custom to cut the longitudinal fibres which were reflected from the ilium to the cæcum and then tear out the gut through the opening in the cæcum.

Dr. Michael has also found great difference in the anatomical structure of the ilio-cæcal valve in different subjects.

Dr. Earl thinks vomiting a less reliable symptom of intussusception than of some other obstructions in the intestine.

Dr. Chambers contends that few, if any, cases exist during life in which substances can be injected from the large to the small intestine through the ilio-cæcal valve.

Dr. Atkinson thinks diagnosis of this trouble more easily made in children than in adults. Children, he thinks, should be operated upon; but, as Dr. Keirle says, 30 per cent. of adults recover without operation, then it is unjustifiable to operate unless we can increase this proportion; and especially are we censurable when the diagnosis is not positively clear, as is often the case in adults.

Dr. Williams related two cases of recovery without surgical interference:

No. 1.—Recovered after injections of large quantities of water while patient was under chloroform.

No. 2.—Recovered after relaxation was brought about by large doses of chloral hydrate.

Uterine Surgery in Spain.—Seventeen myomatous tumors have lately been excised together with the uterus and left ovary, Fallopian tube and lateral ligament, by Dr. Don M. C. Sabater, of Madrid. The patient did well. The total weight of the mass removed was 4 kilogrammes 480 grammes; the largest of the tumors weighing 3 kilogrammes 100 grammes, and measuring 25x20x21 centim.—*Lond. Med. Times.*

TRANSACTIONS OF THE CHICAGO GYNECOLOGICAL SOCIETY.

REGULAR MEETING, FRIDAY EVENING, SEPTEMBER 18, 1885.

I. Dudley—*Remarks upon Abdominal and Gynecological Surgery in England, Scotland and Heidelberg.*

The President, Dr. H. P. Merriman, in the chair.

Dr. E. C. Dudley made some informal remarks relative to his observations in gynecological and abdominal surgery, during a summer holiday in Europe. His observations were confined to the work of a few operators in England, Scotland and Heidelberg.

In Heidelberg, he called upon Dr. Kehrer. Dr. Dudley inspected the hospital and saw evidence of considerable work in abdominal surgery. Dr. Kehrer's laboratory gave evidence of active research into gynecological bacteriology. His work bore the stamp of thoroughness and efficiency. Dr. Kehrer is a medium-sized man, frail and delicate, with a large head and small body.

A call upon Dr. Bantock, at his office, No. 18 Harley Street, W., London, resulted in a pleasant hour's conversation upon subjects pertaining to ovariotomy and hysterectomy. Patients at the Samaritan Hospital sometimes die within twenty-four hours after laparotomy, with a high temperature. This condition was called acute sepsis by certain systematic writers. Dr. Bantock thought the true pathology of the condition was unknown, and was not satisfied with the term, acute sepsis. Dr. Dudley saw Dr. Bantock operate at the Samaritan Hospital. The first operation was the removal of a small, solid ovarian tumor. The remaining ovary and tube, although normal, were removed on account of a small intra-mural, uterine fibroid. The striking feature of the operation was great rapidity without haste. Dr. Bantock caught up the edges of the peritoneum with small compression forceps, so that these edges were drawn up towards the cutaneous edges, and were held in this position by the weight of the instrument against the abdominal surface,

This manœuvre greatly facilitated the passage of the sutures. The pedicle was secured by means of silk ligature, applied in the operator's peculiar figure-of-eight turns.

In closing the wound, a needle of ovoid shape, curved on the edge, instead of on the flat, was employed. This needle combines the maximum of strength with the minimum of size. Two or three sutures were passed through at each angle of the wound. Their ends were joined by knots. An assistant, passing the index finger of each hand through the loops thus formed, made traction at each angle of the wound, in such a manner as to draw its sides into contact, and to lift the peritoneal edges nearer to the surface. The introduction of the remaining suture was in this manner greatly facilitated. The sutures were so closely passed that no superficial stitches were required. They were made to include a very narrow margin of skin and peritoneum, and very little if any muscular tissue. Fine silk-worm gut was employed.

The ends of the sutures, on each side of the wound, were now grasped in lock forceps, which prevented them from being drawn out, or becoming tangled during the separation of the wound for the toilet of the peritoneum, which was most thorough, the entire cavity being rendered perfectly clean and dry. The lock forceps were then removed from the ends of the sutures, and the hands of the assistant substituted. The action was thus made on all the sutures, in the direction of the upper angle of the wound, and they were tied in order from below upward and cut short. This prevents tangling of the threads and otherwise facilitates tying. Antiseptics, throughout the operation, were conspicuous by their absence. The dressings were of the most simple character.

Dr. Bantock kindly showed Dr. Dudley over the hospital, which contained a number of convalescents from hysterectomy, ovariotomy and oöphorectomy. Dr. Bantock's exceptionally good results, in the last operation, are recognized throughout the world. His wonderful statistics in abdominal surgery are due to downright splendid operating. Dr. Meridith, at the same time, was removing a tumor in another room, under the most extreme antiseptic conditions. The famous Samaritan Hospital is an unpretentious building, seemingly a reconstructed dwelling, in the middle of a block, with houses joining on either side, and, like great men, has a modest appearance.

It is generally supposed in America that the Woman's Hospital in the State of New York, established by Marion Sims in 1855, was the first of its kind in the world. This is a mistake. Dr. Sims himself, in a letter to Dr. Protheroe Smith, of London, dated July, 1883, accords to that gentleman the honor of having established the first hospital specially for the treatment of the diseases of women. This hospital, founded in 1842, is now a flourishing institution in London, and is called the Hospital for Women.

Its venerable founder visited Chicago a year ago. Dr. Dudley again met him in London. His enthusiasm for the specialty, in which he has been a pioneer, continues, indeed, seems to increase with advancing years. He retains his official connection with the institution, as senior physician, and is still engaged in active practice. He was among the first, against bitter opposition, to advocate anæthesia in labor. Efforts are now being made, with great promise of success, to raise funds for the construction of a larger and more appropriate hospital building.

Dr. Dudley visited Birmingham, in response to a polite telegraphic invitation from Mr. Lawson Tait. On the train he occupied the same compartment with a sleek, well-fed, high-church London clergyman of the most conservative order, who intimated in no uncertain manner that the conservative people of London looked down upon the inhabitants of the radical city of Birmingham as a semi-barbarous community. So decided was his denunciations of the radical party in general, and of Birmingham in particular, which as the chief stronghold of radicalism always return John Bright and Chamberlain to Parliament, that Dr. Dudley in an apologistic

manner explained that he was only going into the jaws of the Philistines to witness an operation by a distinguished surgeon from whom he hoped to learn something. The clergyman inquired who the surgeon was, and upon hearing the name of Lawson Tait, exclaimed: "O, I know all about him, he is just as bad as any of of them;" which means that Mr. Tait is a radical in politics, as he is in surgery,

Mr. Tait's ridicule of antiseptics is well-known. His rapid method of operating conveys to the casual observer the idea of haste and almost carelessness.

But closer observartion very soon shows him to be one of those rare operators, where dexterity amounts almost to a slight of hand. An ovariotomy, in his hands, does not impress the observer as a capital operation. It seems almost as trivial as opening an abscess. His methods of operating did not differ materially from those of Dr. Bantock. In closing the wound he used but one needle, threaded with a piece of long silk, introducing this as if for a continuous suture, but did not draw the thread tight. After the introduction of the needle, he left a long loop befere the reintroduction. Then, after taking the last stitch, he lifted the free loops of silk on the index finger, and severed them with the scissors, thereby converting the continuous into an interrupted suture. These were tied in the ordinary way, and the wound was dressed in a manner, which would be eminently acceptable to his most bitter antiseptic enemy.

During the day, Mr. Tait performed ovariotomy, lumbocolotomy, perineorrhaphy, and excised a urethro-vulvar cyst, besides attending to a large number of consultations, in one of which Dr. Dudley accompanied him to a distance of forty miles. This was for him only a moderate day's work. It is indeed evident that no other man in England controls a larger practice in abdominal surgery.

Mr. Tait impressed Dr. Dudley as a sincere man of exceptionally strong and positive character and very much in earnest. Like Virchow he is politically inclined; indeed, his temperament is such that he cannot see things go on without having a hand in them. He has taken active part in the city government of Birmingham, and as Dr. Dudley was informed, had already declined to stand for Parliament.

During a brief visit in Edinburgh, Dr. Dudley was pleasantly entertained by Dr. Thomas Keith, who had just returned from a consultation with Dr. Homans in Boston, but unfortunately Dr. Keith did not operate during this time, although a large number of patients were waiting for him at the Royal Infirmary. His son, Dr. Skene Keith, kindly invited Dr. Dudley to an ovariotomy, his forty-eighth operation. Up to this time, he had only lost one or two patients. His operation presented some interesting pecularities. He uses probe-pointed scissors of a peculiar pattern, instead of the director, in going down through the deeper layers of the abdominal walls. By pressing firmly against the adhesions with a sponge, at the point of their attachment to the cyst, he literally sponged them away from the tumor. It was surprising to note the facility with which rather firm adhesions were thus broken. It is much easier to tear them from the tumor with with a sponge than to tear the tumor from the adhesions. The breaking of the adhesions in this way is also much more gentle, and in the opinion of Dr. Keith, diminishes the danger of shock.

The adhesions were ligatured with fine cat-gut as fast as they were divided. In passing the ligatures a forceps, similar to the ordinary compression forceps, was used. This instrument had blades more than an inch long, of very small diameter, terminating in sharp points, so sharp that when the blades were closed they could be thrust through any soft tissue like a large needle. Grasping the ligature in the point of these blades, the tissue to be ligatured was transfixed. The ligature was then pulled through and the forceps withdrawn.

The pedicle was transfixed and ligatured with fine silk, in the same way.

The cautery, to which much of the elder Keith's success has been attributed, was not employed in this case, because the pedicle was very slender. The rea-

son why the cautery in the hands of other operators, has not proved a more perfect protection against hæmorrhage, becomes apparent to any one who has witnessed its application in the hands of Dr. Keith. The whole secret of his method is, first, in the powerful compression of the pedicle between the broad blades of a heavy Baker Brown clamp; second, in the prolonged application of the red-hot cautery iron, not only to the pedicle, but, after this has been burned to the level of the clamp, also to the clamp itself. In this way the clamp becomes so hot that the included portion of the pedicle is slowly and thoroughly cooked, so that when the instrument is removed, the end of the pedicle is thin and translucent, resembling a horny substance. Such a pedicle, in the experience of Dr. Keith, never gives trouble from oozing.

The wound was closed with fine silk sutures which had been boiled. Ten or fifteen pieces of silk were threaded at each end with very finely well tempered needles nearly three inches long, which were introduced on either side from within outward. Very small margins of peritoneum and skin were included in the sutures. Dr. Keith thought it a very common fault among operators to draw the stitches too tight in tying. The long fine needle used in closing the wound is superior. It makes a very small puncture, which never bleeds, and is so fine that it is easily pushed through by means of finger and thumb without needle forceps.

In the *American Journal of Obstetrics*, April, 1880, Marion Sims had given a remarkable description of the Keith operation, which has exerted a powerful and beneficent influence upon the operation in America. Dr. Dudley could add little except the gentle handling of the adhesions with the sponge, the ligature forceps and the peculiar long needles already mentioned.

The wonderful success without antiseptics recorded by the great Scotch ovariotomist, by Dr. Bantock and by Mr. Tait, who have reduced the mortality almost to zero, must have great influence in fixing the value of Listerism so far as it relates to abdominal surgery. At any rate, incompetent operators can no longer venture with impunity upon these capital operations under the dangerous impression, that in some mysterious way, antiseptics will deprive a crude surgical performance of its greatest perils. Evidently it was not so much a question of Listerism as of removing the tumor with the least possible amount of operating, and in the shortest time consistent with careful attention to detail, and in the most gentle manner.

Dr. Dudley, however, raised the pertinent question whether Listerism should be placed on trial before a court of abdominal surgeons, and whether, if found unnecessary in peritoneal surgery, it could be fair to condemn it in general. He thought that such a verdict could not be sustained by the facts, but that the antiseptic principle in surgery was destined to stand. Even the most violent opponents of antiseptics agreed that perfect cleanliness was essential. He knew of no other method by which cleanliness could be rendered so nearly absolute. Nor did the seeming ability or two or three of the most dexterous operators to do without antiseptics prove that it might not be a useful aid to others. Clearly, the man who removes a tumor with the least operating and handling of the parts will require fewer preventive measures against inflammation and sepsis. Antiseptics, therefore, might be most valuable for an inexperienced operator, and, to say the least, an additional safeguard for any one.

Some American operators were now having about as good results as could be shown in Great Britian, which seemed to indicate that our former high mortality in this American operation had been due in reality to bad operating, and not, as many supposed, to climatic causes.

The minor gynecology of Great Britian had apparently made but little progress since the days of Bennett and Simpson. The general impression prevails that on this side of the Atlantic we are going wild in the minor gynecological surgery. In response, we may now congratulate our English brethren that many of their leading gynecologists are

already commencing to comprehend, to appreciate and to perform the American operations of perineorrhaphy, elytrorrhaphy and trachelorrhaphy, and at the same time to lay aside in a measure the old *porte caustique.*

DISCUSSION.

Dr. H. P. Newman said that there were other reasons for the brilliant success of foreign laparotomists than those referred to by Dr. Dudley. Aside from the facility and expeditious manner of operating, acquired by large experience, a prime factor is the justifiable self-confidence of the operator and a responsive confidence inspired in the patient.

Dr. W. W. Jaggard thought that minor gynecological operations, as Dr. Dudley termed them, were less frequent in the United Kingdom and the Continent than in America. Dr. Dudley had made this general assertion, and he agreed with him. He did not, however, think the operative skill of British or Continental surgeons inferior to that of their American *confrères.* The indications for operative procedure do not exist in the United Kingdom and the Continent as in America. Laceration of the cervix and perineum are of much less frequent occurrence. The *cervix uteri* is usually effaced, and the external os is fully dilated before the application of the forceps. Manual dilatation is less frequently practiced. The bag of waters is not prematurely ruptured. Greater care is taken with the preservation of the perineum. In a word, obstetricians are better operators, and do not require so-called gynecological assistants.

Dr. L. J. Doering said that, in 1874, he had been present at ovariotomy and other operations, performed at the Samaritan Hospital by Sir Spencer Wells. He was particularly impressed with the extreme care exercised in admitting spectators to the operations, each visitor being required to sign a statement that he had not made an autopsy or attended a case of contagious disease for the two or three days preceding. He desired to know whether these regulations were still in force, and also if Mr. Lawson Tait and Dr. Keith required similar restrictions.

The President asked the following questions:

1. "Was any treatment given to the patients to prepare them for the operation by any of the eminent gentlemen mentioned?"

2. "How were the patients covered during the operation, or was the whole abdomen left bare?"

3. "How was the evacuation of the cyst managed?"

4. "Was the patient turned upon her side to accomplish this, as Dr. Thomas sometimes does?"

The President suggested that all who desired should ask questions for further light before the general discussion began.

Dr. Christian Fenger replied to the question, raised by Dr. Dudley, that antiseptic precautions might be more important in surgery, in general, than in abdominal surgery, where it looked as though more perfect methods of operating without antisepsis gave as good results as with antisepsis, as follows:

He thought that the abdominal, or rather peritoneal cavity, in respect to the antiseptic precautions, occupies a peculiar position in surgery. The danger from absorption of the poisonous antiseptics is far greater in the abdomen than in the wounds. The ability of the peritoneum to absorb serous fluid and blood before it decomposes, to encapsulate foreign substances not capable of absorption—*ex. gr.*, rubber ligature—is perhaps somewhat greater than the ability of a wound in that direction, although it may be that there is some prejudice about this, as we have not as yet used silk ligatures in general surgery.

As to the question, whether more perfect methods of operating without antisepsis would improve the results, or rather prevent inflammation and sepsis, he could say that outside of the peritoneum this question must as yet be answered in the negative.

In 1873, Volkman, of Halle, introduced the Lister method of dressing and operating in his surgical clinics. In his report of the work done in 1873 (*Beiträge zur Chirurgie*, 1875), the antiseptic

surgery had reduced inflammatory and septic complications following excisions, amputations, fresh penetrating articular wounds, fresh open fractures, to a minimum never before dreamt of, and all this in one year. In the broad field of surgery it is not possible that Volkman or anybody else could improve the *technique* of operating, to the extent of having the results change all of a sudden in that way. No surgeon would dare, today, to excise, for example, a knee-joint, without antiseptic precautions in all the minute details, even if he employed all the latest improvements in the method of operating. Abdominal surgery is the only branch of surgery in which, as yet, the heavy operating has been done without antiseptic precautions.

Reviews, Books and Pamphlets.

The Physician Himself and What He Should Add to His Scientific Acquirements in order to Secure Success. By D. W. CATHELL, M. D., Late Professor of Pathology in the College of Physicians and Surgeons of Baltimore. Fifth Edition. Thoroughly Revised. Baltimore: Cushings & Bailey. 1885. Pp. 274. Price, $2.00.

The success which has attended the publication of this book has been phenomenal, and shows with what marked favor its varied and useful suggestions have been received by the profession. No less than fifteen thousand copies of the work have been sold prior to the publication of the present edition, a fact which but few medical authors can boast of. With each edition of this work the author has made numerous additions and improvements in order to introduce such matured reflections and suggestions as have occurred to his larger experience. The present edition has been thoroughly revised and contains numerous improvements and changes. The author has profited by much of the adverse criticism heaped upon his earlier editions ,and now presents a work which contains much good advice and practical wisdom to commend it to the consideration of every class of readers. The task has been a most difficult one, but the author has accomplished it in a manner to win the esteem and respect of his numerous readers.

BOOKS AND PAMPHLETS RECEIVED.

Manual of the Diseases of Women; Being a Concise and Systematic Exposition of the Theory and Practice of Gynecology. For use of Students and Practitioners. By CHARLES H. MAY, M. D., late House Physician Mt. Sinai Hospital, New York. Philadelphia: Lea Bros. & Co. 1885. Pp. 349.

Post-mortem Examinations, with Especial Reference to Medico-Legal Practice By PROF. RUDOLPH VIRCHOW, of the Berlin Charite Hospital. Translated by T. P. SMITH, M. D., M.R.S.E., with Additional Notes and New Plates. From the Fourth German Edition. Philadelphia: P. Blackiston, Son & Co. 1885. Pp. 138. Price, $1.00.

Practical Histology and Pathology. By HENEAGE GIBBS, M. D., Lecturer on Normal and Morbid Histology in the Medical School of the Westminster Hospital. Third Edition. Philadelphia: P. Blackiston, Son & Co. 1885. Pp. 179. Price, $1.75,

Practical Surgery; Including Surgical Dressings, Bandaging, Fracturers, Dislocations, Ligatures of the Arteries, Amputations, and Excisions of Bones and Joints. By J. EWING MEARS, M. D., Lecturer on Practical Surgery in Jefferson Medical College, etc. With 490 Illustrations. Philadelphia: P. Blackiston, Son & Co. 1885. Pp. 783. Price, Cloth, $3 75; Sheep, $4.75,

The Principles and Practice of Surgery. By JOHN ASHHURST, JR., Professor of Clinical Surgery in the University of Pennsylvania, etc. Fourth Edition. Enlarged and Thoroughly Revised, with 597 Illustrations. Philadelphia: Lea Brothers & Co. 1885. Pp. 1067.

PILOCARPINE IN TOOTHACHE.—If we can relieve this distressing suffering by hypodermic injections of pilocarpine, as Mr. A. P. Kurzakoff, of Moscow, says we can, it will truly prove a great blessing. A solution of two grains of the salt in half an ounce of distilled water was used, the injection being made into the temporal region on the side of the odontalgia. In two of the cases one-eighth, and in a third case one-quarter of a grain of the salt was injected. In all the cases pain disappeared permanently in about an hour after the injection; about the same time salivation and perspiration (caused by the drug) also ceased. In one of the cases, in that of a man aged 46, with rheumatic periodontitis associated with agonizing earache, the injection (of a quarter of a grain) produced profuse vomiting, with cyanosis, general weakness, and drowsiness, all of which symptoms disappeared in about an hour and a half after taking twenty drops of tincture of valerian. The author thinks that this simple plan of treatment fully deserves a further and more extensive trial.—*Med. and Surg. Reporter.*

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BALTIMORE, OCTOBER 31, 1885.

Editorial.

CHANGE IN THE PROPRIETORSHIP OF THE MARYLAND MEDICAL JOURNAL.—With the close of Volume XIII the present proprietor of the JOURNAL transferred this property to the Journal Publishing Company and severed his business relations with the JOURNAL. In future he will devote his attention exclusively to editorial work. All communications relating to the business of the JOURNAL should be addressed to the Journal Publishing Company and those having reference to the editorial department should be addressed to the editor. The present change in the business conduct of the JOURNAL marks a new era in its history and progress. The property of the JOURNAL passes into the hands of a business firm of large enterprise and capital, and its conduct will receive every attention required to give value and success to this work. The new owners of the JOURNAL propose to push along the development of the work with commendable enterprise, and as rapidly as its encouragement will justify. Without inaugurating, at once, any marked change in the style and character of the JOURNAL, it is proposed to add from time to time such features and improvements as will add to the value of the work. Recognizing the fact that Baltimore is fast becoming a great medical centre, an effort will be made to develop the medical interests of this city, but as the JOURNAL proposes to reach every class of readers and to go into new and far distant territory for its support it will also seek to cultivate friendly relations with a large number of contributors in widely separated localities. The labor of editing and publishing a weekly journal is no light task. The editor, therefore, invites the cordial support of the profession in his part of the work, and he asks for the present proprietors such a measure of encouragement and aid as will enable them to improve and push forward their work. After some years of hard struggle and continued effort, the JOURNAL has reached a point from which it can advance to a position of great usefulness to its readers. Its usefulness will be assured if it meets with that aid and support from the profession to which it seems fairly entitled.

THE CHANGE IN THE LOCATION OF THE LIBRARY OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, which has been recently made, is a much desired improvement in the conduct of the Library and marks advanced progress in its growth and usefulness. The present rooms, located in the commodious building on the N. W. corner of St. Paul and Saratoga Sts., are admirably adapted to the purposes of a library and afford ample scope for the large growth of an institution which commends itself, in every way, to the support of the profession in this city and State. The Library had some time ago outgrown the capacity of the quarters on West Fayette St., and the present location was the choice not only of an appropriate sentiment but of an actual necessity. In its present rooms there is a large space for new books and periodicals, which should be filled at an early day by the generous donations of the profession in our city. The growth of the Library must depend in large measure upon the generosity of its friends, and have we no hesitency in urging those who have more books and pamphlets than are actually needed by them to donate them to this institution. The present Librarian, Dr. Cordell, has manifested the greatest zeal and enthu-

siasm in the development of this work and has made innumerable sacrifices in its behalf. He should be held up and encouraged in his disinterested labor of love by the generosity of those who are able to make the Library a most useful repository of the literature of medicine.

How to Build up a Medical Society.—The Academy of Medicine, of this city, has set a good example to other local medical societies by offering a prize of fifty dollars for the best paper read before the Academy during its coming fiscal year. By this method the Academy hopes to stimulate careful and detailed work among its members. There can be no doubt of the fact that a reward is an incentive to effort, and it is believed that a premium set on labor will promote a higher character of service than where no encouragement is given. In addition to this prize the Academy has appointed a committee to devise the best plan of securing a full and accurate report of its meetings for publication. Just here we may be permitted to offer a suggestion. The success which has resulted from the publication of the reports of the meetings of various societies in New York, Philadelphia, Washington, Chicago and in other cities, has demonstrated the fact that no society can reach the full measure of strength and influence which does not furnish its reports to the various medical journals of this country for publication. The reports of a number of societies and scientific bodies are received each week at our office in form for publication. From the matter thus placed at our disposal we select such as we deem suitable for our columns. No labor or expense is imposed upon us in securing these reports, and we naturally give preference to those which best serve the wants of our numerous readers. We have desired to see the medical societies of Baltimore aroused to the importance of having their meetings carefully reported and forwarded to the various journals of our country for publication. Up to this time this method has not been in vogue here, but we are assured that its adoption will lead to most excellent results. From the moment a record is taken of remarks made before a society with a view of wide publication from that moment we will witness an improvement in the work of this society. When encouragement is given to a high standard of debate and discussion the loose, careless and impromptu statements which fall from the lips of ready speakers will become things of the past. Those men who desire to do good work will have attentive audiences, and those who simply talk to be heard will see the necessity of keeping silence. If our societies desire to build up a strong and vigorous body of cultivated medical men in our city they must adopt methods which have proved to be eminently successful in other cities. Baltimore must keep pace with other cities, or fall behind in the race for a high and honorable position in medical and scientific culture.

The *Journal of the American Medical Association* is very optimistic in its views in regard to the Congress. Having persuaded itself that the Congress will be a success under its present management, it assumes that everyone should see this result in the same way. Our contemporary recalls to our mind the picture of the fellow who persistently attempted to lift himself over the fence by his boot-straps. The effort was extremely self-confident and earnest, but the result remaineth to be seen.

Drowning men, it is said, catch on to straws, so does our contemporary, the Journal of the Association. It gives its readers a list of *Journals* which give support to the present Committee on the Organizatian of the Congress, but fails to notice but three Journals which have criticised the action of this Committee. It is probable our contemporary considers the rest of these publications beneath the dignity of a notice. But how about the weighty and ponderous oracles it lifts into notice in support of its side of the questions? Will some one rise and explain the inwardness of this singular freak of approval from the medical press?

Miscellany.

Antiseptics in Midwifery.—S. H. Owen, M. D., Assistant Physician to the Manchester Clinical Hospital, writes to the *British Medical Journal*: At the recent meeting of the Association at Cardiff, the value and importance of antiseptics in ordinary as well as in operative midwifery were strongly advocated. That the hands of the accoucheur should be washed in antiseptic fluid before making a vaginal examination, and that all instruments should be similarly treated before use, were clearly and forcibly enjoined by Dr. Gervis. Beyond this preliminary washing, the use of some lubricant for the hand of the operator, as well as for any instruments that may be employed, is generally considered necessary.

In order to carry out fully the principle of cleanliness, the lubricant itself should be antiseptic. I should like to suggest for this purpose the following: Hydrag. perchloridi, gr. ii; olei eucalypt., ℥j; adipis benzoati, ℥j. This combination has the advantage of thorough antisepsis, a right consistence for lubricating purposes, and a pleasant odor. Its use may be extended with great advantage to the hospital out-patient room, where the examining hand is much more frequently itself infected than the source of infection to the patient.

The Cholera Commission of the French Académie de Médicine.—The *British Med. Journal* says: M. Marey has read before the Académie de Médicine and the Académie des Sciences the result of his investigations on cholera, carried out under the directions of the commission of the Académie de Médicine. According to the medical testimony from the cholera-stricken localities, the disease was ascertained to be imported into at least three-fourths, if not all, of those districts. According to M. Marey's report, the cholera epidemic was less intense in thickly populated towns than in small country places. Dirty habits, especially neglect in removing excreta, are the principal factors in the diffusion of the affection. During a cholera epidemic, the stools of a patient suffering from slight diarrhœa may contain the germs of the cholera. The specific germs are often diffused by patients, and drinking this impure water often provokes the malady. Storm water soiled by the excreta of cholera-which often precede or intensify epidemics are instrumental in rendering drinking-water impure, by carrying along excreta lying on the ground into rivers and other watercourses. In towns, water is better preserved from this contact, and thus cholera-mortality is lower. Some cities supplied by river-water instead of spring water run the same danger as country places. The most dangerous localities during cholera epidemics are those which are situated low, or near rivers, or supplied with water of doubtful purity.

The disinfection of houses, according to the rules laid down by the Comité Consultatif d'Hygiene, is of the greatest importance, and has apparently, in some instances, averted the course of the epidemic. These measures should be adopted as soon as a case of cholera occurs. It is, therefore, necessary that medical men should be qualified to detect even the less typical forms of cholera. Slight choleraic affections often contaminate water, and provoke an outbreak of cholera. Debility, want of cleanliness, the habit of drinking, are all favorable to the malady. Old people and infants are specially liable to be attacked. One attack is no guarantee against recurrence, which is frequent during an epidemic.

A Case of Congenital Vulvar Anus Cured by Operation.—Dr. Aveling states the following case in the *Lancet*:

The patient came under my observation when seventeen years of age. When five weeks old it was discovered that the rectum opened into the vagina at the vulva. An opening was made at this time into the rectum at the normal site of the anus, and this was kept open for two years by the passage of bougies. An attempt was made by the use of caustics to make the vulvar opening close, but without any success. Up to

fifteen years of age the patient suffered from habitual constipation, but very rarely from the involuntary escape of feces. After this the bowels became relaxed and she could only prevent the escape of fecal matter by sitting with the legs tightly crossed.

The vulvar anus readily admitted the index finger on examination, while the artificial anus was rigid and unyielding.

An attempt was made to close the vulvar opening by paring the edges and bringing them together by silver sutures. This was torn open a few days later by a large mass of hardened feces. The operation was repeated twice more before complete closure was effected.

Now another trouble arose. As soon as laxation was stopped the feces became hard and much impacted opposite the site of the former opening, the patient having no power to expel them from this newly-formed pouch.

Another operation remedied this difficulty and established a pretty firm perineal body. This relieved the patient from an annoying sense of want of support in this region, from which she had always suffered. The case illustrates the fact that these patients, who sometimes go through life with their malformation, may be greatly relieved by operation.

It also shows that the closure of the vulvar anus, as proposed by Curling, is not sufficient; but that the portion of the rectum between this and the artificial anus must be obliterated. The author would advise in another case, slitting up freely the perineum and rectum, and having pared the mucous surfaces of the abnormal rectal extension, bring them together by vulvar, rectal and perineal sutures. Some diagrames are given which make the case very clear.

Psychological Aspects of Suicide.—At the recent meeting of the Medical Society of Virginia, Dr. J. S. Conrad, Superintendent of the Matley Hill Sanitarium, near Baltimore, Md., by invitation, read a paper on this subject, and made the following conclusions:

1. Suicide increased with the advance of civilization, and was but little known in the savage state of men.

2. The act was an intelligent act (?) done with a full consciousness of the act, as shown by the method of execution, whether by the sane or insane.

3. That suicide was done always for the purpose of escaping an evil, and for the benefit of the *felo-de-se*, whether by sane or insane.

4. That it was a voluntary act (?), whether by sane or insane.

5. That it was an emotional act, whether by sane or insane, however deliberately planned and executed, since deliberation entered into the mind of both mental states.

6. That delusions were not essential to the distinction as to the saniiy or insanity of the suicide, since authorities affirmed that delusions were not essentail to the proof of insanity.

7. That suicide was rare in the first class—insanity (by Maudsley), viz., intellectual or ideational insanity—but did not occur in the vast majority of the second class, or affective or emotional forms of insanity.

8. Query: Was suicide an intellectual act notwithstanding the intelligence exercised in its execution? Or was it an emotional act *per se*, since we had seen that the emotional part of mind dominated the ideational centers and perverted the intellect into becoming its humble servant?

9. Did moral depravity satisfactorily account for it, when we had seen moral depravity was a factor with both the sane and insane.

10. That, in doubtful case of the sanity or insanity of the *felo-de-se*, very great caution was necessary in making up a just judgment as to the one or the other

A New Test for Albumen in the Urine.—In the *Medical Chronicle* for September, Dr. Thomas Harris details the results of a series of trials with a test first suggested by Dr. William Roberts about a year ago. The test consists of a mixture of one volume of strong nitric acid with five volumes of a saturated solution of magnesian sulphate. It forms a very dense fluid which is as clear as water, does not fume, and does not

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stain or burn anything with which it may come into contact. It is used exactly in the same way as the cold nitric acid test, and care should be taken in adding the urine to slope the test tube so as to avoid as much as possible a free mixing of the urine with the test solution. If albumen be present, a well-defined band will be formed exactly at the line of junction of the two fluids, its degree of opacity varying with the amount of albumen, but it is always sharply defined, and just at the junction. When the quantity of albumen is very small, some little time may be required for its development. This test also precipitates mucin; the ring thus formed appears just above the junction of the urine and test fluid; it is broader and less dense than that indicative of albumen, and shades off gradually above and below. This test further possesses the advantage of giving no reaction with the peptones, and it does not liberate iodine from the urine in the case of persons taking iodide of potassium to the same extent that nitric acid does, and is therefore suitable under such circumstances for the recognition of small quantities of albumen. Dr. Harris proposes to call this test the magnesian nitric test.—*London Med. Times.*

Dextrine Paste for Freckles (Unna):—

Oxide of zinc,	ʒ ii.
Oxychlorate of Bismuth,	℥ss.
Sublimate,	grs. 3.
Dextrine	
Distilled water each,	℥ii.
Glycerine	ʒ iii.

Make into a consistence of a paste.—*Jour. de Mèd. de Paris.—Canada Pract.*

Earache and Toothache.—H. Bendelock Hewetson, of Leeds, writes in the London *Lancet* that he has found the glycerinum acidi carbolici invariably to relieve the pain in toothache and earache, and especially in cases of inflammation of the middle ear. He claims that if the treatment is used early, perforation of the tympanum can be stayed in many cases.

Medical Items.

The Veterinary Department of the University of Pennsylvania is now fully opened. It has been organized at an expense of about fifty thousand dollars, with Dr. Huidekoper at its head. The buildings now completed are extensive and well suited to their object. They contain stalls, sweat-baths, foot-baths, a padded cell for lunatic horses, an armory for instruments, forges, lecture rooms, working laboratories, dissecting room, and in fact, everything necessary for studying the diseases of the lower animals under the most favorable circumstances. A large part of the building is to be used as a hospital for sick or injured horses, cattle, sheep, dogs, cats, etc.

The present Secretary-General of the Congress is more highly responsible for the present muddle of the affairs of the Congress than the Committee of Arrangements, which is but the organization of his adoption and will.

Professor Hæser, of Breslau, author of a well-known "History of Medicine," has lately died at the age of 72. The death is also announced of Professor F. Baeckman, of Warsaw, where he had been professor of pharmacy and chemistry for many years.

The Russian medical authorities have sent Dr. Raptshevski to Spain to study the cholera-epidemic and Dr. Ferran's inoculations.

The death of Professor Dr. Starkes, chief physician of the Charitè in Berlin, and lecturer in the Military Academy, is announced.

Dr. William Lee, who, from the beginning, has been assistant editor of the association *Journal*, has, we understand, been dismissed by the editor. Dr. Lee was appointed by the original committee a member of the council of the Section in Physiology of the Ninth International Medical Congress, but resigned after the Chicago meeting of the New Orleans committee. *N. Y. Med. Journ.*

Coccus of Vaginitis in Children.—A Hungarian physician has examined the vaginal secretions of a number of little girls who were suffering from all kinds of chronic diseases in a children's hospital, with the result that the coccus which existed in all was, according to the observer, identical with Neisser's gonococcus, and with that found in vaginal blenorrhœa.—*Lond. Med. Times.*

From a recent estimate it appears there are in London sixty-seven hospitals of all kinds. They afford accommodation in beds for 6,588 patients, and on an average 56,493 in-patients occupy these beds annually. The same hospitals make medical provision for out-patients, and 530,564 out-patients are also received. At the present time, many of the London hospitals are financially in a bad way on account of the present great fall in the revenue obtained from their landed investments. Many have had to close some of their beds, and are now making earnest appeals for funds.

Salicylate of Cocaine Hypodermically.—Salicylate of cocaine has been tried as a hypodermic injection in an obstinate case of trigeminal neuralgia by Max Schneider. It acted marvelously well; 0.4 gramm was injected under the skin of the cheek. This was repeated several times, and almost entirely relieved the pain and the distressing insomnia. Galvanism completed the cure. —*Lond. Med. Times.*

At the annual meeting of the Washington Obstetrical and Gynecological Society, held on October 16, 1885, the following officers were elected for the ensuing year: President, Dr. A. F. A. King; Vice.Presidents, Drs. W. W. Johnston and J. Taber Johnson; Recording Secretary, Dr. C. H. A. Kleinschmidt; Corresponding Secretary, Dr. S. S. Adams; Treasurer, Dr. G. B. Harrison.

It is stated that Professor Huxley is about to retire from his various appointments under Government with a pension of £1,200 a year.

Dr. F. A. Castle, from the Board of Trustees of the New York Academy of Medicine, reported that $2000 had recently been paid, which constituted the final payment in liquidation of the original mortgage of $10,000 on the building, so that the Academy is now entirely free from debt.

Menthol has been extensively used in New York city as a remedy for hay fever, and with some success.

The following is original with the *Medical Record:*

Little drops of water,
Little grains of milk,
Make the little doctors
Of Homœopathic ilk.

Dr. E. O. Shakespeare sailed October 10th on his mission to Spain, to gather information concerning the cholera epidemic. He will go direct to Berlin, where he will gather data in Dr. Koch's laboratory. From Berlin he will go to Madrid to present his letters and credentials to the American Minister, and will then proceed to Barcelona. Most of his studies will be made in Lisbon. He will remain in Spain, altogether, about five months.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department U. S. Army, from Oct. 20, 1885, to October 26, 1885

Col. T. A. McParlin, Surgeon. Ordered to await further orders in New York City.

Maj. Anthony Heger, Surgeon. Limited in addition to his present duties as member of Army Medical Examining Board now in session in New York City to perform the duties of attending surgeon in that city.

Maj. Joseph C. Bailey, Surgeon. Granted leave of absence for 20 days.

Maj. D. L. Huntington, Surgeon U. S. Army. Detailed on Board to inspect Army and Navy hospital buildings at Hot Springs, Ark.

1st Lt. C. C. Barrows, Asst. Surgeon. In addition to his other duties, to take temporary charge of office of the Medical Div., Ariz.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service for the two weeks ending Oct. 24 1885.

Long, W. H., Surgeon. To proceed to Detroit, Mich., and assume charge of the Service. Oct. 23, 1885.

Austin, H. W., Surgeon. To proceed to Albany, N. Y., on special duty. Oct. 14, 1885.

Williams, L, L., Asst. Surgeon. Relieved from duty at Norfolk, Va., to proceed to Washington, D. C., for temporary duty. Oct. 20, 1885.

Original Article.

OBSERVATIONS ON SUNSTROKE AND HEAT EXHAUSTION.*

BASED ON THE RECORD OF FIFTY CASES ADMITTED INTO THE PENNSYLVANIA HOSPITAL FROM THE MIDDLE OF JULY TO THE MIDDLE OF AUG., 1885.

BY ORVILLE HORWITZ, M. D.,

Resident Physician at the Hospital.

In presenting this paper to the medical profession, the writer deems it proper to state that it is done solely with a view to call attention to the therapy of the cases of sunstroke and heat exhaustion which were received into the Pennsylvania Hospital during the months of July and August, for he cannot help feeling that a line of treatment which will bring about favorable results when the temperature has risen to 112°, is worthy of being recorded.

He acknowledges his indebtedness to Dr. Joseph Kirkebride, who was physician-in-charge of the medical wards of the hospital during the summer months, for permission to publish the results of the cases.

The first patient was admitted on the 16th day of July; the average of the thermometer being 95° F. in the shade.

The second case of sunstroke was received July 17, when the thermometer stood at 99.5° F. in the shade. This man was brought in at 11 A. M. He had fallen whilst employed in loading his cart with dirt.

He was unconscious and very restless. His breathing was noisy and labored; respiration 27; pulse 165, strong and full. Temperature 109°.

He was at once immersed in a tub of ice-water and removed, when the temperature fell to 99° F. He was then put to bed and covered with a sheet saturated with ice-water. Ice was applied to his head. A hypodermic of tincture of digitalis (♏ xx), with an anal injection of antipyrin was administered.

At 11.30 a tendency to convulsions was observed. The temperature was reduced to 102°F. A second injection of antipyrin of gr. xx was ordered, which had the effect of reducing the temperature to 99⅘° F.

Two hours after admission the patient began to regain consciousness, but he appeared to be greatly alarmed, and feared that those about him would do him bodily harm. He very soon became violently delirious, and a state of acute mania was developed.

He was cupped at the nape and behind the ears, and about ten ounces of blood were drawn. He now became quiet, when a quarter of a grain of morphia was administered hypodermically.

After the administration of the second dose of antipyrin the temperature never exceeded 99° F. The patient was discharged cured on the ninth day.

The individual who was brought to the hospital on the 21st of July was admitted at 2.30 P. M.; the thermometer at the time stood at 100° F. in the shade. His friends stated that whilst assisting in laying the street cable he suddenly complained of violent headache, which was followed by vomiting. He drank freely of ice-water and fell unconscious on the street.

When admitted he was completely unconscious; his breathing was labored; his pupils dilated; his skin was of a dark reddish hue; the capillaries filling very slowly when emptied by pressure.

His temperature was 112° F., pulse 162, and irregular; respiration 33. His sphincters were relaxed, accompanied by involuntary discharge of feces.

Treatment.—At 2.45 P. M. he was packed in ice and a bucket of ice-water sprinkled over him with more or less force. Five minims of aqua ammonia, with twenty minims of whiskey, followed by twenty minims of tincture of digitalis, were administered hypodermically. In fifteen minutes his temperature was reduced to 99⅘°.

The ice-water was now removed; he was then covered with a sheet wrung out of ice-water; ice-water being at the

*Read before the College of Physicians of Philadelphia. Stated Meeting held October 7, 1885. The President, J. M. Da Costa, in the chair.

same time applied to the head. His respirations were quick and shallow.

He was now given one-sixtieth of a grain of atropia, together with twenty-five minims of whiskey. By 3.10 P. M. the temperature had risen to 104⅘° F. His pulse being weak, the hypodermic of aqua ammonia and whiskey was repeated, and forty grains of antipyrin were administered per anum. At 3.30 P. M. the temperature was 99⅘° F., a hypodermic of ether was administered, and the patient was again covered with a wet sheet. At 7 o clock he was slightly conscious, when he was given ten drops of tincture of digitalis, with a hypodermic of twenty minims of whiskey, repeated every fifteen minutes. At 8 o'clock the whiskey was omitted and a small quantity of pancreatized milk, with lime-water ordered. At 9 o'clock calomel (gr. x), bicarb. soda (gr. x), and bromide of sodium (gr. xxx) were given; the last-named article to be repeated every third hour.

The patient was somewhat dazed for two or three days; he was discharged cured on the twelfth day after admission.

On the same day, July 21, a farmer, who had been working in the sun, was admitted. He had driven his wagon to market, and on reaching Front Street was seized with a violent headache, accompanied by sickness at the stomach, for which he took a large dose of whiskey, and fell to the floor unconscious as soon as the liquor was swallowed.

At 1.30 P. M. he was brought to the hospital. On admission his temperature was 109° F.; pulse 158; respiration 30; pupils contracted; involuntary discharge of feces.

He was at once placed in an ice-bath and given twenty minims of tincture of digitalis with one-sixtieth of a grain of atropia. His temperature fell to 99° F., when he was removed to bed and covered with an ice-water sheet; his temperature soon rose to 104⅘° F. Antipyrin, sixty grains, per anum, was ordered, and in addition twenty minims of whiskey, hypodermically, every fifteen minutes were administered.

An hour and a half after admission the patient was seized with violent convulsions. A half of a grain of morphia, with one sixteenth of a grain of atropia were administered. He was then placed under the influence of ether. The convulsions continued for the space of an hour, when the administration of musk, in ten-grain doses, per anum, was resorted to. The convulsions entirely ceased after the administration of the third dose of musk.

The individual gradually became conscious. Two days after admission meningitis was developed. He remained in the hospital under treatment for six weeks, when he was discharged cured.

On the 24th of July a woman, who was a cook, was received into the hospital suffering from great exhaustion. She was a strong healthy-looking German. When admitted her temperature was 110° F.; pulse 160; respiration 35.

For the first hour after her admission she was treated by Dr. Horwitz; after that she came under the care of Dr. Penrose. She was at once wrapped in a wet sheet, surrounded by pieces of ice, and ice-water was sprinkled over her. A hypodermic of aqua ammonia fort. (gtt. v), tincture digitalis (gtt. xxv), and subsequently a hypodermic of atropia sulph., gr. $\frac{1}{60}$, were administered. Under this treatment her temperature fell to 99°; pulse 80; respiration 25.

The patient vomited and purged continually. Sinapisms were applied to the chest, abdomen and thighs, which caused marked reaction. After this, hypodermics of tincture of digitalis (m x) and ether (m x) and a suppository of ten grains of carbonate of ammonia, were administered. Ice was kept to the head constantly. This line of treatment was continued for fifteen hours. The temperature did not again rise above 100° F.

The patient slowly and gradually recovered, but did not begin to move about the hospital yard until September 19.

July 26, a laborer, was admitted, who had fallen to the ground whilst engaged in paving the streets.

When received he was unconscious; his breathing was stertorous; pupils contracted; temperature 108⅘° F.; pulse 159; respiration 30; bowels relaxed; he vom-

ited immediately after admission.

An ice-water bath was at once prescribed; a hypodermic of five drops of aqua ammonia administered, followed by tincture of digitalis, m xx. In fifteen minutes his temperature fell to 99° F.

He was removed from the tub and covered with a sheet wrung out of ice-water. Ice was applied to his head. His respiration being short and rapid, one-sixtieth of a grain of atropia was ordered. Ether, twenty minims, hypodermically, was admistered, and dry cups were applied to the posterior base of the lungs. His temperature now rose to 103⅘°, when antipyrin (gr. xxx) was administered per anum.

One hour after admission the patient was seized with violent convulsions, for which was prescribed one-half of a grain of sulphate of morphia hypodermically, and he was placed under the influence of ether.

The tendency to convulsions continuing, a suppository of thirty grains of musk was ordered; to be repeated every half hour.

Under the influence of the first dose of antipyrin the temperature fell to 99⅘° F.; at the end of a half hour the temperature again rose to 104° F. Sixty grains of antipyrin, dissolved in eight ounces of ice-water, per rectum, were ordered, with the effect of reducing the temperature to 99° F.

About three hours after his admission he became conscious, when he was given calomel (gr. x) with bromide of sodium (gr. xxx); the latter to be repeated every three hours. The patient was discharged cured August 8.

The foregoing are presented as types of the fifty cases that were admitted into the Pennsylvania Hospital during the months of July and August, with a synopsis of the treatment pursued.

Of those received into the hospital, *twenty-four* were cases of sunstroke, and *twenty-six* suffered from heat exhaustion.

Of the *twenty-four* cases of sunstroke, *nine died. Three died* within *ten minutes* after admission, and cannot fairly be said to have been subjected to treatment in the institution.

Four died within *six hours* after admission. *Two died forty-eight* hours after admission.

Of the nine that died, *four were hard drinkers; two were strictly temperate*, and *three drank in moderation.* Twenty-one out of the twenty-four had violent convulsions; one had acute mania, lasting one hour and a half.

The maximum temperature was 112° F.; this patient recovered.

The minimum temperature was 94⅘°; this was a case of heat exhaustion.

Twenty out of the twenty-four cases of sunstroke occurred between July 16 and July 26.

The largest number received on any one day was on Wednesday, July 22, when nine cases were admitted. The thermometer on that day stood at 93$\frac{5}{10}$° F. in the shade; on the two previous days it rose to 100° F. in the shade.

But two opportunities for post-mortem examinations presented themselves. In one case, which resulted in death ten minutes after admission, the temperature being 109° F., congestion of the lungs and kidneys was found to exist, with slight injection of the arachnoid and pia mater. In the remaining case, the individual dying two days after admission, there were presented the usual evidences of commencing meningitis.

On examination of the blood, the corpuscles were found shrivelled in a few cases, but in the majority the microscope revealed no change.

Albumen was present in the urine in all but two cases, and this condition continued for two or three days after convalescence.

Treatment.—The *antipyrin* was used in all cases, in large doses, with the effect to keep down the temperature after it had been reduced by the application of ice, ice-bags, and ice-sheets to the surface; it was employed in the form of enemata, but the writer suggests that it would probably be more potent if used hypodermically. It was not resorted to unless the temperature showed a decided tendency to rise.

Musk seemed to be decidedly advantageous in controlling the violence of the convulsions; it was administered in doses of ten grains, and by the time the

ten grains were given the convulsions, as a rule, ceased. This remedy was administered in sixteen out of twenty-one cases of convulsions, and in all these it was of marked and immediate benefit; the violence of the attack was rapidly abated, and soon ceased to exist.

Aqua ammonia, in doses of five drops, repeated as occasion required, doubtless saved several cases, when the patient was about to die from heart failure, when the heart-sounds were indistinct, and when the pulse at the wrist could with difficulty be felt.

Ether hypodermically acted as a better stimulant than whiskey; administered by inhalation it controlled the convulsions, acted as a heart stimulant, and improved respiration in a marked degree.

Bloodletting.—One individual was bled from the arm to the extent of twelve ounces; he died two days after from meningitis. Four persons were cupped at the nape, or behind the ears; about eight ounces were abstracted in each case. They all recovered.

The individuals in whom bloodletting was resorted to were all strong, full-blooded, heavy men, with injected conjunctiva, the veins of their necks standing out prominently; the pulse being full and bounding; convulsions setting in early.

Dry cups, employed in the sunstroke cases, were valueless; but, in those affected by heat exhaustion, the benefit was well-marked and immediate, the patients *invariably* regaining consciousness after their application.

Tincture of digitalis, in twenty minim doses, administered when the patient was first seen, acted as an excellent heart stimulant. The pulse at once became fuller and slower, the heart beating more regularly.

Quinine, used after antipyrin had caused the temperature to drop, was of marked benefit.

When the patients became conscious, *calomel*, gr. x, and *bromide of sodium*, gr. xxx, were administered—the latter repeated every third hour for the space of forty-eight hours, or longer, depending on the condition of the patient.

[After the reading of the preceding paper:—]

Dr. H. C. Wood said: The use of musk, as detailed in the paper just read, is, I believe, new. Antipyrin has, however, been used in one of the New York hospitals, and a paper written thereon by the resident physician.

There is one point which is worthy of consideration by hospital authorities. I have noticed myself, in experiments on animals, that time is of the utmost importance in the treatment of sunstroke, and our clinical experience accords with this. If the moment the animal became unconscious, I reduced the temperature by cold, the animal invariably recovered; if, however, it was left for ten or twenty minutes, reduction of the temperature caused benefit, and usually return of consciousness, but there were almost always marked signs of an impaired nervous system, and in a large proportion of cases death from paralysis. In the New York Hospital, antipyrin was given to the ambulance surgeon, and thus the remedy could be administered at once. I myself think that in very hot weather the hospital ambulance should be provided, not only with antipyrin, but also with ice, and no time would be lost, the remedies being applied as the patient was being brought to the hospital. The patient could be half undressed and rubbed with ice, and antipyrin could be used hypodermically.

Very few writers report the time which has elapsed before treatment after the sunstroke; and without such report statistics are of little value, because one of the most important elements of the case is omitted.

Dr. J. M. Da Costa said: It is but fair to Dr. Horwitz to state that this use of antipyrin is, so far as I know, original. Looking at these cases, it will be found that they were treated in July, while the paper alluded to, which has escaped my notice, appeared in August; it is evident, therefore, that he had thought of antipyrin himself.

In regard to musk, I have been utterly unable to find any referenee to its use in the convulsions of sunstroke, and I am glad to hear so distinguished an authority as Dr. Wood state that it has never been used before for the purpose.

The use of opium, or rather of morphia, hypodermically, for the arrest of the convulsions of sunstroke, also originated, so far as I know, in the Pennsylvania Hospital, and was published some years ago.

Society Reports.

PHILADELPHIA ACADEMY OF SURGERY.

STATED MEETING HELD OCTOBER 5, 1885.

Vice-President Dr. R. J. Levis in the Chair.

FOREIGN BODY CAUSING VESICAL CALCULUS.

Dr. J. Ewing Mears: I desire to present to the Academy a urinary calculus removed from a patient in St. Mary's Hospital three weeks ago. The patient was a man from the interior of the State, 56 years of age, who had been suffering with bladder-trouble for nine months. There had been difficult micturition with pain, and the diagnosis of inflammation of the bladder had been made. Six months ago, in order to relieve the difficulty in passing water, he said that he had introduced a straw some two or three inches long. He was under the influence of liquor at the time, and the straw slipped from his grasp and entered the urethra. His symptoms then became more marked, and he came to this city. I introduced a sound, and discovered in the bladder the stone or mass which you see. The urine was carefully examined, and it was found to contain a large quantity of albumen and also phosphatic deposits. The question arose, in view of the man's habits, his age, and the condition of the urine, whether it would be better to perform lithotomy or lithotrity or litholapaxy. Under the circumstances, I considered lithotomy the preferable operation.

I cut the man, and in so doing opened an abscess in the prostate, evacuating about an ounce of pus. I then entered the bladder and removed this cluster of calculi with a scoop. The bladder was then washed out, and in two weeks the man returned to his home with wound entirely closed. At the end of this time, examination of the urine showed that its character was greatly improved.

It was certainly fortunate that section of the perineum was decided upon. The abscess was not recognized before operating, although exploration of the perineum was made. There was no pain, no swelling, and no tenderness.

The question arises in such cases as this, where the age of the man, his habits, and the composition of the urine indicate serious vesical and possibly renal disease, whether it is better to perform lithotomy or the crushing operation.

Dr. Levis: How would the introduction of a straw account for this fimbriated character of the mass? If a head of wheat or barley had been passed, it might explain it.

Dr. S. W. Gross: Close examination will show that this is a spear of some grain, and that these little calculi are formed around the hairs of the grain.

Dr. Nancrede: Could not the albumen in the urine come from the abscess in the prostate?

Dr. Mears: It did not seem possible that the abscess communicated with the bladder. When I opened the abscess, I at first thought that it was connected with bladder; but further examination showed that such was not the case. The abscess might have been due to the impaction of one of these little masses in the duct of the gland, for I neglected to say that he had passed a number of these masses through the urethra.

EXCISION OF THE SCAPULA.

Dr. John Brinton: I have a specimen which I removed on Saturday last. It is of a good deal of interest; first, from the character of the tumor, and, secondly, from the magnitude of the operation required for its removal. The operation consisted in the removal of the entire scapula, performed on a girl of eleven years of age for a formidable tumor. I may say here that the operation was unsuccessful as far as the life of the girl was concerned, as the patient sank rapidly from shock, and died an hour after the termination of the operation.

The history of the case is simply this: A little girl, 11 years of age, living in the interior of the State, while playing under an apple-tree growing on a declivity, caught hold of one of the branches and swung herself. The branch gave way and she fell backward, rolling some six or seven feet, and striking the scapula upon a little projecting edge of stone. The pain from this continued for about an hour and then passed away, and there was no more trouble until last April, when she began to complain of pain over the right infra-spinatus fossa of the scapula. About the latter part of May or the early part of June swelling made its appearance, and gradually increased until the tumor assumed formidable dimensions. At the time I examined it, the base of the tumor measured fifteen inches in circumference, and the general thickness of the shoulder was four to five inches greater than on the opposite side. The child was suffering greatly. The pain during the daytime was somewhat paroxysmal, but during the night it was almost continuous. For a number of nights she received from ten to fourteen drops of laudanum to give relief. During the night preceding the operation she was carried in a chair to give her as much rest as possible.

The case was seen in consultation, and the diagnosis of rapidly-growing sarcoma was made. It evidently involved the whole dorsum scapulæ. After looking up the statistics of the operation, I decided to attempt the excision of the whole scapula. I ought to state that the parents were fully apprised of the nature of the operation, and all the parties concerned accepted the risks, owing to the urgency of the case.

On Saturday last the child was etherized, and, beginning at the point of the acromion process, I made an incision, carrying it to the posterior edge of the scapula. The incision was not at first carried the entire length, because I wished to divide the acromio-clavicular articulation as soon as possible. The idea was to save every drop of blood that could possibly be saved. I had gathered from the reports of cases that the great peril was from hemorrhage. I therefore commenced with a moderate incision, so as to divide the acromio-clavicular articulation. The incision was then swept across to the posterior portion of the bone. An incision was next made at right angles, and the incision (somewhat curved) was carried below the angle of the scapula and the four flaps dissected up. Then I commenced at the upper part of the bone, dividing the muscles; and then passed slowly down, dividing the muscles,—taking the precaution, where there was any chance of considerable hemorrhage, to include the mass of muscle within a ligature before dividing it. Where there was no danger, a mass of tissue was grasped between two large forceps, such as I formerly used for the extraction of bullets. The incision was then carried along the posterior border and the muscles divided; it was next carried under the inferior angle of the bone and the parts raised. The incision upon the anterior costa of the scapula was carried up, the vessels being compressed; and thus the parts being lifted, I opened the capsular ligament and turned out the head of the humerus. I next divided the heads of the muscles attached to the coracoid process. I had already divided the muscles along the spine. The bone was then readily lifted up and the hemorrhage was comparatively small. Performing the operation in this way, only one or two vessels required ligature after removal of the bone.

Examination of the tumor shows that it consists of two portions; that upon the dorsum, which is incised, and my finger goes directly to the bone, which is entirely destroyed, showing that the growth sprang from the periosteum. In examining the case before the operation, Dr. Gross and myself noticed a mass inside of the axilla. I, myself, thought that the mass must depend upon a prolongation of this mass of morbid structure. It, however, depended upon a mass of tissue developed from the venter of the bone. These masses are continuous at the juncture of the upper and middle third of the inferior costa. It was the posterior mass which projected into the axilla. This

lifted the scapula from the chest and increased the apparent size of the tumor on the dorsal surface.

Statistics show that the mortality following the operation is greater where a portion of the bone is left than where the entire bone is removed. In forty cases of entire removal, the mortality was twenty per cent.; after partial removal, twenty-one or twenty-two per cent. Where the scapula was removed after amputation of the arm, the mortality was twenty-four per cent.

The microscopical examination of this growth by Dr. Longstreth shows that it is a well-marked example of round-celled sarcoma.

One other case of complete excision of the scapula was performed by Professor Agnew some years ago. The patient died in a short time from shock. Two partial operations were performed by the late Professor Gross.

Dr. R. J. Levis: Once, when contemplating an operation of the same kind on an adult with a large tumor—an operation which I did not perform—I determined upon an expedient to prevent severe hemorrhage. That was to tilt out the scapula and apply Esmarch's bandage around it, enclosing the axillary artery high up. To prevent slipping, a bandage was to be placed in front, under the rubber tube, drawing it to the opposite side.

Dr. J. Ewing Mears: We would not expect much hemorrhage from a tumor which seems, as this does, to be, as it were, encapsulated. In this case the muscles are not attached to the growth. Where, however, there is a malignant growth which infiltrates the tissues and envelopes the ramifications of the blood-vessels, the bleeding may be severe and prove fatal.

I would ask Dr. Brinton if, when he turned up the mass towards the axilla, he brought into view the axillary vessels?

Dr. Brinton: I did not. I saw the sub-scapular artery and nothing else.

Dr. Mears: I refer to that point for this reason: that in some cases, where the growth involves the entire arm, it is necessary to extirpate the scapula with a portion of the clavicle, and also the entire arm, and it has seemed to me that in such cases it might be possible, by tilting up the scapula, to reach the axillary artery and surround it with ligature before amputating the arm. I have not found this method controlling hemorrhage prior to disarticulation referred to.

In considering the mortality-rate after excision of the scapula, it is desirable to consider the causes for which the operation is performed. It has been performed for necrosis, for gunshot injuries, and for tumors such as enchondromata, sarcoma, and malignant growths. In necrosis of the entire scapula, where the disease is of some duration and where there is great inflammatory thickening of the periosteum, removal of the scapula is comparatively easy. An incision made along the spine to the posterior border and then continued along the posterior border will enable the operator to lift the periosteum with an elevator periostome or the handle of a knife. In that way the muscular attachments may be severed. Such an operation gives a better mortality-rate than do operations for malignant growths, and, if I remember, better than for operations for the removal of portions of the bone in compound comminuted fractures, the result of gunshot injuries.

Dr. Brinton: In this case there was no difficulty in compressing the subclavian artery with the finger. This was done by Dr. Hearn. In some of the reported cases the pressure has been made directly. In some of these cases, as soon as the acromio-clavicular articulation has been severed, the coracoid process has been broken and pressure made directly upon the artery.

Dr. Levis: Did the patient seem much depressed by the anæsthetic?

Dr. Brinton: She came from under the ether very well.

Dr. Hearn: The child was never thoroughly anæsthetized at any time. I do not think that the anæsthetic had anything to do with the fatal result.

CONGENITAL MALFORMATION OF COLON.

Dr. Charles B. Nancrede: I have here specimens of some little interest.

They are the terminal part of the rectum and the caput coli, which were removed from an infant, 50 hours old. The child had been delivered with instruments, and seemed to be in perfect health until the second night, when the nurse sent for me and said that there was something wrong; that the child was crying and straining, but had not soiled any napkins.

On examination, I found a well-formed anus, into which I could introduce my finger one-third of an inch. It was a female child, and I could therefore make a thorough examination; but I could detect no bulging at any point. As it was twelve o'clock at night and the distention was not great, I gave an opiate, and the next morning at eleven o'clock Dr. Ashhurst met me in consultation. Neither of us could feel any bowel, but we thought it right to make an effort to reach the bowel. I dissected along the hollow of the sacrum up to the promontory, but could not feel the gut. We then decided to perform the operation in the right inguinal region, and I opened what I supposed to the signoid flexure; but it proved at the post mortem to be the caput coli. As soon as the peritoneal cavity was opened, about an ounce of serum escaped, and with it the right Fallopian tube, which was intensely congested. There was marked peritonitis. The child lived four and half days after the operation. The meconium passed freely, and afterwards the discharge was natural. The child died from exhaustion, evidently due to the peritonitis.

The post mortem showed that if I had detected the bulging bowel, which I must have felt, as it was near the end of my incision, I should almost inevitably cut through two layers of peritoneum. There was a space about as wide as a director where the bowel was not covered by peritoneum, and I should have left behind the peritonitis. The question arises in these cases, if peritonitis does set in so early, and if death results, as it usually does, from peritonitis, whether it is worth while to add the double danger of two operations, especially in female children where it is impossible to detect any sign of the bowel.

Dr. Levis: Does Dr. Nancrede think well of operating before the sac becomes distended?

Dr. Nancrede: Unless something is done, the patient dies early. I noticed that Bryant has called attention to the fact that peritonitis sets in very rapidly, and that in true obstruction death is frequently due to peritonitis. In this case the peritonitis was very marked at the end of fifty hours.

Dr. Levis: I have never done any operation except in the fundament. I would not like to save a child's life with an anus anywhere but in the fundament. I have always been able to find the sac and bring it down and stitch it to the skin.

Dr. O. H. Allis: At the post mortem, how far were the two blind sacs from each other?

Dr. Nancrede: I should say about an inch. I must have touched the bowel with my finger, but did not recognize it. Bryant strongly advocates the operation in case of deficient rectum, and the opinion of a man who has had such an exceptionally large experience in the surgery of the bowel in general, having reported eighty-two or eighty-three colotomies, ought to count for a good deal. There seemed to be no more difficulty in retaining the fæces in this case than where the anus is in the normal position. Sometimes hours would pass without anything coming. In this case I think it would have been impossible to bring the bowel down and stitch it.

TREATMENT OF CARBUNCLE.

Dr. James Collins: I have lately treated two cases of carbuncle on the back of the neck by a method which seems to have some advantages. The patient is put under the influence of an anæsthetic and a linear incision made. I then take a scoop and remove all the necrosed tissue, and wash the parts thoroughly with an antiseptic solution of mercuric chloride. I then put in a drainage-tube, and insert two stitches to bring the central parts together. Each day the cavity is thoroughly washed out with the antiseptic solution. The pa-

tients have done well, and the cicatrix has been less than after any other method I have tried. The success depends upon the removal of the necrosed tissue and the use of the antiseptic solution.

Dr. S. W. Gross: The plan of Dr. Collins is, I think, based upon proper principles. I consider it far the best operation yet suggested. By scraping away all the dead tissue he gets rid of the micrococci which produce putrefaction, which give rise to the sloughs. The application of the corrosive sublimate destroys the micrococci which line the walls of the cavity, and in that way removes the cause of the disease.

Dr. Mears: I would ask if Dr. Collins, in scooping out the dead tissue, found anything like a thickened wall limiting the mass to be removed, and if he was able to satisfy himself that he has removed all the dead tissue.

Dr. Collins: I keep on scooping out until I reach a denser structure. The difference seems to be in the denseness of the tissue. The healthy tissue seems to be firm.

Dr. Levis: The operation of excision of carbuncles in their incipiency has been repeatedly advised and practised. In cases of constantly-recurring carbuncle I think excision would be of service.

Dr. Hunt: I have been trying to recall a case of carbuncle on the back of the neck of a woman. I cannot recall a case. I would ask if this is the experience of the other members, and, if so, what reason can be given for this peculiarity?

Dr. Collins: I remember one severe case.

Dr. Levis: I cannot recollect a case.

Dr. Nancrede: I have seen a fatal case in which the carbuncle was on the side of the neck of a woman.

The *Northwestern Lancet* says: Keith, of Edinburgh, recently came to Boston to give an opinion on the case of a lady who had an obscure abdominal affection. He remained in consultation with the regular attendant about half an hour, confirmed the previous diagnosis in the case and went home with a fee of $10,000.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD OCT. 1, 1885.

The President, DR. B. F. BAER, in the Chair.

Dr. Wharton Sinkler read a paper on

THE DIFFERENT FORMS OF PARALYSIS MET WITH IN YOUNG CHILDREN.

The most frequently met form is infantile spinal paralysis, or *polio-myelitis anterior*. This term indicates the pathology of the disease which is an inflammation of the nerve cells of the anterior horns of white matter of the spinal cord. This affection may come on at any period of life, but is generally seen in children, and usually at the age of ten years. The children are generally strong and apparently healthy, and the paralysis is sudden in its onset. Fully two-thirds of the cases I have seen have been attacked in the summer months, hot weather and teething seeming to be predisposing agents Dr. Barton, of Manchester, England, reports that of fifty-three cases in which he noted the time of onset, twenty-seven occurred in July and August. The attack is preceded by fever of greater or less intensity, with pain in the head and limbs with general soreness when moved or lifted. After a few days, paralysis more or less complete occurs, but in a few days a regression of the paralysis from some of the affected parts occurs. Sensation is undisturbed. Atrophy of the muscles is soon apparent, in fact the paralyzed portion stops growing for a time. The temperature of the affected portion is low and the skin is blue and mottled, but there is no tendency to ulceration, and wounds and scratches heal readily. The skin and tendon reflexes are lowered or abolished in the affected limbs. At first response to the farradic current is lost, and later on the galvanic current produces but little muscular contraction, except where a powerful current is used. Where atrophy has set in the reaction of degeneration is seen. Most of the cases of club-

foot are the result of infantile palsy. Deformities of the upper extremities are rare; this disease differing in this respect from cerebral palsies. The exact causes of infantile palsy are unknown. Overfatigue often precedes an attack; sudden chilling is considered by Seguin to be a frequent cause.

The *prognosis* as to perfect recovery is only moderately good. In many cases the most faithful treatment fails to restore the paralyzed muscles, but in almost every case we can expect more or less improvement.

In the early stages of the paralysis, after subsidence of the fever, the treatment should consist of mild stimulation to the spine; ergot and small doses of bromide of potassium should be given internally. Later in the disease, iodide of potassium should be given instead of the bromide. When the palsy is established, electricity and massage are the means to be depended upon. They must be persisted in for months or even for years. Internal treatment is of little or no value unless there is some failure in the general health of the child.

Spasmodic Paralysis as seen in children is of two varieties. When of primary spinal origin, or, when there is a descending degeneration of the cord from a primary cerebral lesion, sometimes there seems to be a congenital defect in the motor tracts of both brain and cord. In the spinal variety there is often seen, soon after birth, rigidity of the limbs; at first this is only occasional, but as the child gets older every effort to move a limb causes muscular rigidity in it. The child does not attempt to walk until three or four years of age. Then when it is supported under the arms and it tries to stand or to walk the movements are very peculiar and characteristic. The feet are extended and inverted so that the child rests on the toes. The knees are strongly adducted and lock together so that the legs become entangled. By degrees the child becomes able to walk with the aid of apparatus or some form of crutch. The hands and arms are often affected and every effort causes muscular rigidity to come on. The mind is unaffected in these cases and the speech may be distinct although it is often very defective. Sensation is unimpaired and the patella reflex and ankle clonus are exaggerated. There is no wasting of the muscles. By these symptoms we infer that the disease is localized in the lateral columns; but exactly what is the nature of the lesion we do not know, for no post-mortem examinations have been made in these cases. The cause is unknown. Hamilton found that three of seven cases which he had collected were premature births. Adherent and contracted prepuce has been thought by some to be a cause by reflex influence of the spasmodic paralysis, but operation has not given relief. The treatment should consist of massage, galvanism to the spine, ergot and cod liver oil. Fluid extract of conium may be given to allay spasm. In some cases great improvement follows this treatment.

Paralysis from Pott's Disease.—Paralysis of the lower extremities may result from caries of the spine. The lesion may be either a meningitis or a myelitis. If meningitis alone, there is considerable pain and contraction of the legs. Generally there is a transverse myelitis. The symptoms are numbness and pricking of the legs with loss of sensation; gradually increasing loss of power with wasting of the muscles; incontinence of feces with retention or incontinence of urine. Sometimes there are ulcers over the sacrum or on the limbs.

The indications for treatment are evident. An apparatus which will take the weight of the body from the spine is necessary, and is sometimes sufficient of itself. Frequently, however, the application of the actual cautery over the spine brings improvement in the symptoms when an apparatus has done no good. Massage and electricity should be used to restore the atrophied muscles.

Paralysis from Rachitis and Diphtheria is seldom complete. The former is often spoken of as the pseudo palsy of rickets. Negro children, who are very subject to rachitis in cities often have rachitic paralysis. The child at three or four years is unable to walk or stand. Sometimes it has not sufficient muscular development to sit upright. It

can move every limb and has no loss of sensation but has no power. Cod liver oil and massage bring about the most satisfactory results in these cases.

Diphtheritic Paralysis usually begins in the muscles of the soft palate and pharynx and extends to the extremities. It is generally bilateral and incomplete, but I have seen a case in which it was hemiplegic. It is considered peripheral in character, and is believed by some to be connected with the altered condition of the blood consequent on the original attack. Diphtheritic paralysis is rarely fatal and lasts in most cases only a few weeks, although it may continue for months. Strychnia and electricity are the means to be employed, and the case usually responds promptly to these remedies.

Pseudo Hypertrophic Paralysis is a rare affection but is of much interest. The disease belongs almost exclusively to infancy. It is characterized by muscular paralysis with great increase in the bulk of the muscles. This enlargement is due to fatty deposit, while the muscular tissue proper is atrophied. The affection begins with weakness of the legs, a peculiar balancing of the trunk and separation of the legs in walking. The shoulders are thrown far back in standing and walking. There is great difficulty in getting from the sitting to a standing position. Later in the disease the muscles become wasted and shrunken, and the general health begins to suffer. Death results from implication of the respiratory muscles. The skin is mottled like a piece of castile soap. The tendon reflexes are abolished and electro-muscular contractility is impaired. There is no loss of power over the bladder and rectum, and sensation is not affected. Heredity influences the disease, which is slow in its progress, but the course is steadily downward.

Frederick's Disease is still more rare than the preceding. It is practically locomotor ataxia in childhood. There is evidenced here also a hereditary predisposition, and the female children seem most liable.

Cerebral Palsies.—Hemiplegia may result from some iujury at the time of birth either from the forceps or from the pressure of a prolonged labor. A child may be born hemiplegic after a perfectly natural and easy labor. Under these circumstances we must regard the paralysis as the result of imperfect cerebral development. Hemiplegia under these circumstances is generally permanent. The side affected grows less rapidly than the other. The flexions of the arm and hand are usually contracted. The leg becomes rigid in the act of walking.

Convulsion is almost always associated with cerebral paralysis, either immediately preceding the attack or occurring soon after. The convulsive movements are most violent on the side which is subsequently paralyzed. The child will have an idotic expression and speak indistinctly, but their friends think them intelligent. The convulsions are liable to return when the child is older and then assume an epileptic form. The walk is peculiar and is called the *spastic* gait. The patient plods along looking as if he were about to pitch forward. The affected limbs are smaller and shorter, the growth of both bone and muscle being affected. In the chronic variety, where the arm is in constant motion, the muscles may become hypertrophied but the bone remains short.

Prognosis.—As a rule the prospect of recovery is bad, even if the patient gets well the hemiplegic side remains awkward.

Treatment.—Cod liver oil and massage, which always relaxes the contracted muscles. The affected limbs should be used as much as possible. (*The paper, with illustrative cases and details of treatment, will be published in full in the Archives of Pediatrics*).

Dr. Harris inquired if Dr. Sinkler had ever observed any hereditary predisposition to convulsions and cerebral paralysis.

Dr. Sinkler replied that the hereditary influence was decided even when no convulsions occurred.

Dr. R. P. Harris read a report of the autopsy upon Mrs. Reybold, from whom two living children had been removed by *Cæsarean section* by Prof.

Gibson, of the University of Pennsylvania. The superior strait was reniform; conjugate diameter 1¾ inches, transverse diameter 5¼ inches. The malformation was due to rachitis and injury from a fall in her second year. A full report of the history of the patient, the operations and the autopsy can be found in the *American Journal of the Medical Sciences*, October, 1855, p. 422.

OOPHORECTOMY.

Dr. E. E. Montgomery reported the following case: Mrs. L., of Columbia, Pa., æt. 36 years, married ten years, pregnant five times, the last four years ago, was brought to my notice by Dr. A. F. Chase. Her health has been bad since her last confinement. First menstruation at twelve and a half years, regular and very free for one and a half years when she fell producing pelvic distress, after which for seven years the flow was very scanty, lasting but one or two days and accompanied by excrutiating pain. She improved somewhat after marriage. Her first conception was followed by so much nausea, vomiting and anemia that her physician advised and induced an abortion

She is now regular as to time but irregular as to quantity; it is preceded by an excrutiating pain for two days and continues until the flow disappears; she also has severe pain in the head. She is very nervous at all times, but this is much intensified during the period. Pain is more marked in the left inguinal region and down the corresponding limb. Coition and vaginal examination are very painful. The uterus is enlarged and painful, tender on pressure over both ovaries. Local uterine treatment had been kept up during the entire four years with no relief. Trachelorraphy had been performed. Ovariotomy was advised. September 19th, 1885, she entered my private hospital, and assisted by Drs. W. H. and C. B. Warder and E. Eshleman, the uterine appendages were removed. The left ovary was composed of a number of cysts, the largest of which ruptured while adhesions were being separated. The right ovary was not enlarged, but it was removed to ensure relief. The wound was closed with silk-gut and dressed with sublimated gauze and absorbent cotton. There was no shock. The highest temperature reached was 101.6° at midnight of the 20th, and it became normal on the 22d. Sutures were removed on the eighth day and the wound re-dressed for the first time. It had united throughout, and there was no irritation from the sutures. The effect upon her general health remains to be determined.

Dr. Montgomery also reported a case of

SUPRA-VAGINAL REMOVAL OF THE UTERUS AND BOTH OVARIES FOR FIBROID TUMOR.

Ann U., æt. 27, was brought to me by Dr. T. H. Bryson, of Egg Harbor City, with the following history: Her menses from the beginning occurred every three weeks and were free an entire week. During the last four years they have occurred every two weeks and are attended with pain in the pelvis and down the limbs, and severe pressure upon the bladder causing frequent urination, and several times necessitating the use of the catheter. Dr. B. had diagnosticated fibroid tumor, which my subsequent examination confirmed. The tumor was the size of a child's head, filling up the pelvis and apparently arising from the anterior wall. The examination led me to believe that the bladder was adherent over the anterior surface and would render the removal of the tumor unsafe. I suggested the removal of the ovaries. She entered my private hospital Sept. 15th, 1885, for that purpose. Drs. W. H. Warder, Boysen and Martin assisted, Dr. C. B. Warder and Stultweather present. An incision three inches long was made and finding the tumor free from the bladder, with cervix sufficiently long to serve for a pedicle, the incision was extended to within an inch of the umbilicus above and symphysis below, and the tumor, with some difficulty withdrawn. In the absence of a Tait's clamp, which had been ordered some days before, the pedicle was constricted by a wire ecraseur and the tumor with the ovaries was removed. The pedicle was then transfixed

with two steel pins and tied in three sections with strong silk thread. The peritoneum was fastened to the pedicle below the ligatures and the wound closed with silk gut sutures, the pins holding the stump outside. The wound was dressed with sublimated gauze and absorbent cotton. The operation was followed by some shock; temperature 97.4°, pulse 104, from which she soon rallied. She complained greatly of pain. A half grain of morphia had been given by suppository and three hypodermatic injections of morphia, ¼ grain each, were given during the afternoon before the pain was relieved.

At 3 A. M. of the 24th, I was called by the nurse, who reported bleeding from the stump. Three ounces of blood had been lost. By aid of Dr. Warder a Wells' clamp was applied below the pins apparently controlling the hemorrhage; but it recurred later in the day from the angles and from beneath the clamp. By this time the Tait's clamp had arrived, and the patient was etherized, the lower three sutures removed the pedicle drawn up, the clamp applied so as to control it completely and the wound again closed. The wound had united throughout. Temperature reached 100.6° at 9.30 P. M. The highest subsequently, 101.6°, was in the afternoon of the 25th, and it became normal on the 28th. Upon removing the dressings on the 27th some pus welled up about the pedicle. As the skin was irritated, the dead pedicle was cut away until the clamp slipped off. There resulted, of course, considerable retraction of the stump, but the sloughed tissue is now nearly cleared away. The patient suffers no pain or discomfort, temperature normal. The tumor was situated in the anterior wall and fundus of uterus and projected into the uterine cavity.

Dr. Parish remarked that removal of the ovaries had given such good results in cases of uterine fibroids and was comparatively so free from danger, that he would like to hear from Dr. Montgomery his reason for his choice of operation.

Dr. Montgomery replied that the tumor filled the pelvis and pressed upon the bladder and rectum causing great and constant distress as diminution of the size of the fibroid tumor is not a certain result of oophorectomy; and as all the circumstances were in favor of the major operation he decided upon it as the best one.

Hospital Reports.

PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL.

MONTHLY REPORT FOR OCTOBER.

Dr. Julian J. Chisolm, Surgeon in charge of the Hospital, reports 2478 persons as the attendance for the month of October, or 91 patients for each day of the month; of these 492 were new cases. During the month 119 operations were performed. The attendance for the 10 months of the year 1885 number 5193 new patients, upon whom 1055 operations have been performed for the cure of eye, ear and throat diseases. Since the first of January, 1885, there have been 112 operations for cataract, 57 iridectomies for glaucoma or closed pupil. There have been 106 cases of squint, 37 enucleations of the eye-ball and 8 evisceerations. This last operation of removing the contents of the eye-shell, leaving the empty sclerotic in the socket, does not meet with favor at the Hospital. The operation is a very easy one, much more so than the removal of the entire eye-ball. It takes much less time and is accompanied by much less hemorrhage. A hole is cut into the eye-ball just behind the union of the cornea and sclerotic. With a knife or scissors following the margin of the cornea a circular incision is made which isolates the cornea and permits it to be taken off as a lid to a box. The contents of the eye-ball is then scooped out by detaching the choroid from the sclerotic by a blunt spade shaped scoop or spoon. When bleeding ceases 3 or 4 points of interrupted suture in the conjunctiva alone closes up the opening made in the eye-shell by the removal of the cornea. The advantage claimed for this operation is that the facia of the socket is not disturbed, the muscles are not separated from the

sclerotic, the hemorrhage is less, and a better stump is left for the adjustment of an artificial eye. Dr. Chisolm has found by his experience in 8 cases of evisceration that convalescence is much more tedious and that the slow healing process is much more painful. Cases of enucleation seldom remain in the hospital more than one day, and often leave before the 24 hours expire, apparently running no risk whatever. The socket rapidly heals and work can be resumed in a very few days. With evisceration the patient has to remain days under observation and treatment. During the eight years since the Hospital has been in operation 233 eye-balls have been removed for painful disease, and not in a single case has any trouble ensued. Often eyes have been removed as a sure, safe and speedy means of putting an end to the severe suffering of panophthalmitis. The eyes have been found full of pus and the socket tissue saturated with inflammatory deposits Even in these serious cases no inflammatory extension towards the brain has ever occurred and relief has been most prompt. Dr. Chisolm has resumed the enucleation of lost eyes as the best operation, having already found the new operation of evisceration not so satisfactory.

For cholera infantum Dr. J. Lewis Smith recommends:

℞.—Tinct. opii.,	gtt xvj.
Spt. ammon. aromat.,	ʒ ss to j.
Bismuth subnitrat.,	ʒ ij.
Syr. simplicis,	ʒ ss.
Mistur. cretæ,	ʒ jss.—M.

Sig.—One teaspoonful every two or three hours to a child of eight to twelve months, until vomiting and diarrhœa are controlled.

Dr. Atlee's Will.—The will of the late Dr. John L. Atlee bequeaths $1,000 to the Orphan's Asylum of Lancaster; $1,000 to the Bishop Bowman Church Home, and $1,000 to St. James' Episcopal Church for the support of the rector. The remainder of the estate is given to the direct heirs, Dr. Walter F. Atlee receiving the surgical instruments of his distinguished father. The estate is valued at $250,000.—*Med. and Surg. Rep*

The American Medical Profession *v.* The Association.—The real trouble in the case of the Washington Congress is that under the direction of a few gentlemen prominently interested in the American Medical Association, the local issue of the Code has been forced upon an international scientific body. There was no justice or right in this, and it was in violation of all precedent and of tacit pledges made at Copenhagen. The consequence of their action is that a large number of our country's best physicians are incapacitated from holding any position in the meeting, and, of course, cannot with self-respect take any part in the work of a body which impugns their professional respectability. The profession has almost unanimously condemned this action. In proof this we give here a list, which we believe is complete, of the journals in this country that have disapproved of the course of the Association: *New York Medical Journal*, *Boston Medical and Surgical Journal*, *The Medical Record*, *Chicago Journal and Examiner*, Maryland Medical Journal, *Medical Age*, *Philadelphia Medical Times*, *Louisville Medical News*, *Atlanta Medical and Surgical Journal*, *Virginia Medtcal Monthly*, *Indiana Medical Journal*, *Pacific Medical and Surgical Journal*, *American Practitioner*, *New Orleans Medical and Surgical Journal*, *Cincinnati Medical Journal*, *Columbus Medical Journal*, *Medical News*, *Kansas City Medical Index.*

We believe that there is not one of the few medical journals that defend the course of the present Committee which has not some official or close personal connection with the organization of the American Medical Association and the Congress.—*Med. Record.*

Professor Litzmann has resigned the Professorship of Midwifery and the direction of the Obstetric Clinic in Kiel.

Dr. Samuel G. Armor, Professor of the Principles and Practice of Medicine in Long Island College Hospital, died in Brooklyn, N. Y., Oct. 27th, at the age of sixty-eight years.

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BALTIMORE, NOVEMBER 7, 1885.

Editorial.

THE CHLORIDE OF SODIUM AS A PREVENTATIVE OF CALCULOUS DISEASE. The study of the influence of various geological formations in the causation of calculous disease has received much attention during recent years, and has led to the enunciation of a number of theories which have thrown some light upon the etiology of the disease. It is pretty clearly established that the prevalence of calculus in certain districts is due to the presence of local conditions, and its absence from other sections of the country may be accounted for in a similar way. We have before us a very instructive paper "On the Cause and Distribution of Calculous Disease," (*London Medical Times*, October 10, 1885) in which the author, C. B. Plowright, M. R. C. S., surgeon to the West Norfolk and Lynn Hospital, undertakes to show that a comparatively stone-free district in Norfolk, England, is due to the influence of salt as an article of food. Mr. Plowright presents facts to prove that in the district of Marshland the calculous disease is very uncommon, and he attributes this condition of things to the character of the water consumed by the inhabitants of this district. Marshland consists of a tract of flat alluvial country, which, in great part, almost within historic times, has been reclaimed from the sea, which, even now, is kept back by a series of banks. The natural water supply is surface water—only ditch-water, in fact—there being no streams and comparatively few wells. Of late years this has been supplemented—(1) by rain water stored in cisterns; (2) by a water supply to Wisbech, which is conveyed across Marshland in an iron main, and of which the villages through which the main passes have availed themselves. So impregnated is the soil with salt that only a few wells yield potable water. This water is usually mixed, one pail-ful with two of rain water. The amount of chloride of sodium thus consumed is very large. Taking two districts the fact remains that on one side of a river where the waters are salt, there is less stone than on the other where it is not the case. This fact has led the author of this paper to a line of enquiry, which we will now follow. If the presence of salt in drinking water has any tendency to lessen the frequency of calculus we should expect to find that a deficiency or an abundance of this substance in the dietary of the inhabitants of other parts of the kingdom will have a similar effect. To test the value of this proposition the author offers facts to show that when salt was taxed in the time of the Commonwealth and its consumption was thereby limited, that there was a distinct increase in the number of cases of calculous disease during the salt-tax period, and subsequently after the removal of this salt-tax the diminution of calculous cases continued in spite of the fact of the population of the country doubling itself. He also makes the observation that the salt counties of England are very free from calculous disease. The same observation holds good for Scotland. In the north of Scotland, including Orkney, Shetland and the Hebrides salt fish enters largely into the dietary of the poorer classes and they enjoy a great immunity from the disease. This same immunity exists among the sailors of the British navy who live for months on highly salted beef and pork. Thus from 1st of January, 1800, to 1st of January, 1816, the navy comprised annually 162,000 men and boys from the

age of nine to sixty years. During these 16 years only eight cases of calculus occurred among the above, and of these only five originated at sea. Arguing from the foregoing facts the author considers that there is a considerable amount of evidence indicating that the presence or absence of salt in the dietary has a determining influence upon the frequency or rarity of calculus. He next considers the way this is brought about. It is evident, he says, that salt promotes thirst, and as a result more fluid is consumed and more passes through the kidneys in a given time. The urine is thus diluted and there is less chance of its solid parts separating in the form of gravel or calculus. In closing this article the author offers the following conclusions, which present a well-defined statement of his views and suggestions:

(1) "That there exists in Norfolk a district (Marshland) in which calculus is much less common than in other parts of the country.

(2) That in Marshland the natural water supply contains a large proportion of salt.

(3) That calculus was relatively more common during the period of the salt-tax than before or after.

(4) That the disease is rare amongst sailors who consume much salt.

(5) That it is more common amongst the children of the poor from whose dietary salt is almost absent, than amongst those of the middle and upper classes where this is not the case.

(6) That the disease in common in India where salt is taxed.

(7) That the presence of salt greatly increases the solubility of uric acid.

(8) That the consumption of salt by increasing thirst ensures a larger amount of fluid passing through the urinary tract, and therefore lessens the probability of calculus.

(9) That by keeping the colloids equally diffused salt tends to prevent the crystalline solids of the urine from agglomerating into calculi.

And lastly, that the facts above stated warrant us in recommending a more liberal consumption of salt by those who are in any way threatened with calculous disease, either by hereditary tendency or by premonitory symptoms—especially those at the two extremities of life who reside in calculous districts. Particularly does this apply to infants and young children—the former, of course, through the mother, for we know that sodium chloride is one of those salts which freely passes from the maternal system into the mammary secretion."

Oil of Yellow Sandal Wood in the Treatment of Gonorrhœa and its Complications.—It is quite well-known that sandal oil and other substances of that nature are supposed to exert a beneficial influence upon gonorrhœa. It has been supposed that when taken into the system it becomes excreted by the kidneys in some altered form, and being mixed with urine comes in contact with the mucous membrane of the urethra and exercises a healing influence over the inflamed tissues. This view was held by Ricord, and, so far as we know, has not been disputed until the present time. In a recent article in the *Annals of Surgery* (Nov. 1, 1885) Dr. Robert Wharry, of London, combats this theory and offers as a substitute a new explanation of the influence of copaiba and sandal wood upon the inflamed urethral mucous membrane. He believes that the influence of these drugs acts in two directions, first while circulating in the capillaries of the urethral mucous membrane and, second, while passing with the urine. It seems to us that the mode of action—which is altogether problematical—is of less importance than the clinical facts which Dr. Wharry offers to show the beneficial influence of oil of sandal wood in cases of gonorrhœa complicated with epididymitis and rheumatism. He brings forward a series of cases to prove that this drug has a prompt action in relieving swollen testicle and gonorrhœal rheumatism after other drugs have been tried and found wanting.

Indeed, Dr. Wharry's results are so satisfactory that one might be induced to believe that the oil of sandal wood is a specific for all forms of gonorrhœal troubles. His suggestions are entitled to consideration, for whilst the remedy is not

altogether a new one for this affection, so striking a confirmation of its clinical value should encourage its more frequent employment. We see one practical drawback to its general use in the high cost of the drug, but it may be an economy in the long run if it has the specific value claimed for it.

Miscellany.

Hysterical Paralysis and Its Treatment.—The *Brit. Med. Journ.* says: "In the difficulties which sometimes arise in the diagnosis of hysterical conditions, the physician must often have wished himself a second Ariel, able to watch his Miranda unperceived, upon a desert island. If the solitude were absolute, and if the stern pressure of want of food were called in, some paralysis would disappear, and some appetites would improve. We have learnt of late years a great deal that enables us to classify many nervous diseases upon the basis of a visible and constant organic pathology, and we are constantly anxious to add more to the list, but some important maladies, such as epilepsy, hysteria, and megrim, steadily baffle the microscope; and, what is worse, hysteria sometimes baffles diagnosis. The more trouble is spent upon it, the wider seem the conditions it may include. Hysterical paralysis has been for long troublesome, needing some easy sign of recognition, in place of the long and patient watching which may often prove the only path to diagnosis, unless a rapid guess be hazarded. It was thought at one time that some faith could be prudently put in the indications of the tendon-reflexes; that, if the limb were in a hysterical contraction, it would have no increased tendon-reflex such as generally accompanies contraction due to organic disease; and, again, that if it were slack and powerless, there would not be the same great diminution of tendon-reflex that there is generally in organic paralysis, of cerebral or spinal origin, before a descending generation has set in. Tendon-reflexes, it was considered, were out of voluntary control if properly examined, and no tricks could be played with them. But, unfortunately, even though the subject may be unwilling, it seems as if Nature could play tricks with them nevertheless.

MM. P. Marie and Souza-Leite have recently, in the *Revue de Médecine*, from observation of cases collected at the Salpetrière, published a group of instances of paralysis which show themselves to be what we would call purely hysterical, by their rapid transference from side to side, or sudden disappearance, and yet to which the tendon-reflexes varied in all ways, sometimes following the general rules of organic paralysis, and sometimes reversing them. However, when we have sufficiently clearly established the ordinary rules of tendon-reflex in organic paralysis, if we find some cases contradicting them, we may justly suspect them to be without organic origin; but we cannot hope to detect all hysterical paralysis by such tests, as many show symptoms in this respect identical with the abnormalities due to organic disease. The first case in which M. Charcot, in 1865, established by the microscope a so-called typical instance of sclerosis of the lateral columns, was thought in life to be entirely hysterical; and, on the other hand several cases since observed which showed symptoms not to be distinguished from the first, and were presumed to be organic after the same fashion, have been carefully shown to have, after death, no organic abnormalities. The extent to which morbid nervous symptoms may go without a pathology, should serve the useful purpose of keeping us humble in our claims to have acquired the key to all the processes of the nervous system. On the other hand, the possibility that a case which looks hysterical may possibly be organic, or partly organic, cramps treatment by the fear of mistake. To treat a monoplegia of genuine organic origin as hysterical, may look brutal, or even criminal. For there can be no doubt that a strong emotion, or a strong imperative, might do away with some symptoms that seem the exact counterpart of others left untouched, but which are in reality very different from them; and herein arises one of the points of

difficulty between the quack or the fanatic and the scientific physician. The first may use methods involving impossible hypotheses, or extravagant sentiment; but he succeeds in calling up the strong emotion or in assuming, in the patient's" eyes, the authority for the strong imperative, and thereby attains his ends much more triumphantly than the physician who will not simulate the emotion he does not feel, or pretend to believe what he knows to be false. There is a great force of emotion that acts in one way at Lourdes, and in another in Exeter Hall, but which may be applied in either case to the relief of discomforts that are none the less real because they are often misnamed. The physician, when science has made his knowledge certain, and his methods of command more varied, may hope to assume an equally effective imperative, or even to find some mental methods that involve no deception"

The Limitations of Colotomy in Disease of the Rectum.—Dr. Charles B. Kelsey, in an elaborate paper in the October issue of *The American Journal of the Medical Sciences*, defines the following as the indications for colotomy:

1. In congenital malformations of the rectum or anus in children in which a tentative operation in the perineum has failed to reach the rectal pouch.

2. Intestino-vesical fistulæ.

3. In tumors occluding the rectum which cannot be relieved by any other means—dilatation, division, hot water, or electrolysis.

4. In non-cancerous, simple or specific stricture and ulceration of the rectum (with or without fistulæ), where the disease cannot be relieved by proctotomy or dilatation, or division of the fistulæ and local treatment of the ulceration.

5. In cancer where the disease can neither be removed nor the passage reestablished, and where death is probable from obstruction—except in cases where the immediate dangers of the operation more than counterbalance any good likely to be gained by it.

6. In volvulus or intussusception of the colon or sigmoid flexure, where reduction by the aid of laparotomy has been found impossible.

The Surgery of Scrofulous Glands.—(*Med. Times*, Jan. 10th and 17th) Dr. Teale, in two clinical lectures, delivered at the Leeds Infirmary, summarizes his experience of the last seven years in the operative treatment of scrofulous glands. The following are his general conclusions:

1. Our guiding principle should be, that whenever septic material is contained in the system, we do not rest until it is expelled, and its burrows laid open and disinfected.

2. In the majority of cases of "scrofulous neck" seen, there was no evidence of any constitutional taint or disease. The origin of the ailment was clear and defined—as bad drains, scarlet fever, mumps, etc. The cases were often isolated instances in families free from any tendency to constitutional disease. The removal of the condemned glands was very rarely followed by any further enlargement of glands, or by the need of a repetition of the operation.

3. Surgical interference is not only justifiable, but demanded: (1) whenever a sinus resulting from a degenerating gland exists; (2) whenever pus can be detected in connection with an enlarged gland; (3) whenever enlarged glands are accessible in a patient in whom a caseous or suppurating gland has been already discovered.

4. The question of removing glands not having suppurated, nor having proven caseous in a single instance, yet which are an eyesore, or accompanied by lowered health, may still be considered an open one. Probably in some of these cases cautery puncture will be considered the best method of treatment.

In regard to the surgical treatment, the following principles are laid down:

1. Surgery can bring about in a few weeks the healing of gland cavities and sinuses, though of years' duration, and of wounds resulting from the removal of caseous and suppurating glands.

2. In dealing with sinuses, gland abscesses, and broken-down glands, the treatment must be vigorous and thorough.

3. The visible abscess, often called and treated as a strumous gland, is, as a rule, merely a subcutaneous reservoir of pus, the gland from which it comes being *not*

subcutaneous but *sub-fascial*—sometimes even sub-muscular—the communication between the two being often only large enough to admit a small probe or director.

4. It is futile simply to puncture such an abscess without removing the gland deeper seated.

5. When a damaged gland is removed before the overlying skin is thinned by suppuration, the resulting scar is slight.

6. When depressed cicatrices resulted, there had been, in almost every instance, long standing sinuses present.

7. In dealing with a sinus, the channel should be enlarged by a knife or "Bigelow's sinus dilator," and the whole of its granulating surface scraped off. When a shallow sinus is covered by thin blue skin, this should be rasped away by the scraper, and any overhanging cutaneous edges to be trimmed off with scissors.

8. In dealing with an abscess, the surgeon should in no instance rest content until he has discovered and eradicated the gland, always remembering that if it be not obvious, there is sure to be a small track leading through the deep fascia to the missing gland; this should be enlarged to admit the spoon of the scraper.

9. When the gland has not suppurated, and is movable, it can be removed with very little dissection, almost by enucleation, and the resulting scar is insignificant.

10. When a gland has suppurated, and generally when it has become caseous, the capsule should be freely opened and the contents eviscerated by Lister's scraper. This is sometimes quite difficult, the tough lining stump being closely adherent to the capsule. This remnant should be dissected away, even at the risk of injuring other structures.

11. Sometimes, after such evisceration, the finger detects the bulging wall of a contiguous gland. This should be opened and removed through the wall of the cavity. Thus, three or four may be removed through one external opening, when in close contact and broken down or suppurating.

12. The cavity, after removal, should be well cleansed by a carbolic acid solution (1-40), and then charged with iodoform. A rubber drain, reaching to the farthest recess, is fixed to one extremity of the wound, the edges of this being carefully brought together by fine catgut sutures. The whole is covered by an antiseptic absorbent dressing. The tube should be removed in a week. It is rarely necessary to remove it. Should a further drain be necessary one of gilt wire should be inserted, which should remain until all is healed except the track of the tube.

Of the various scrapers used, Dr. Teale prefers that devised by Lister, the cup of which is oval, almost circular, and the handle long and having a double curve. Bigelow's "sinus dilator," which works on the principle of an ordinary glove-stretcher, he finds a valuable instrument in these cases.

Syrup of Hydriodic Acid in Acute Inflammatory Rheumatism.—Two years ago Dr. James Craig, of Jersey City, published a paper on the value of hydriodic acid in acute inflammatory rheumatism, and in the *New York Med. Journ.*, August 8, 1885, he states he has yet to find a case in which the syrup, being properly used, has failed to meet his expectations. Since the publication of his first article this method of treatment has been employed by a number of physicians with success, shortening the duration of disease, relieving pain, and reducing temperature, and in all cases leaving the patient without heart complications, the remedy preventing exudation and organization of plastic material. He orders the syrup in from two to three teaspoonful doses in a wine glass of water every two hours, lessening the dose as improvement takes place, and continuing the syrup for about a week or ten days after symptoms have disappeared, so as to ensure recovery and prevent relapse.

Dr. Craig also states that syrup of hydriodic acid is a good remedy in subacute rheumatism, but that its action is not as prompt as in the acute form. He also has tried it in chronic rheumatism, but cannot say that he has observed any good results. He reports sixteen cases, in all of which a prompt cure is stated to have been produced by the use of this drug.—*Ther. Gaz.*

Medical Items.

The new buildings of the Medical Faculty of McGill University were thrown open to the pub'ic on Oct. 22d. The address at the inaugural ceremonies was delivered by Professor Wm. Pepper, of Philadelphia.

Dr. G. W. Mayor, of Montreal, has declined to serve on the Council of the Section of Dermatology in the International Medical Congress, and Dr. J. G. Curtis, of New York City, has refused the position assigned to him.

The *Boston Medical and Surgical Journal* says: It is stated by the daily papers that the anti-vaccination crank who stirred up most of the resistance to vaccination in Chicago and Montreal, on being arrested, was found to have been vaccinated three times, the last time within a few weeks.

Two men were quarrelling. One of them threatened to shoot the other. The threatened man, in revival of an old piece of sarcasm, asked: "Where do you bury all your dead?" Just then an excited man drew the satirist aside, and said: "My gracious! you ought not to talk that way!" "Which way?" "Asking that man where he buries his dead." "Why?" "Because he is a physician."—*Ex.*

The American Academy of Medicine, which recently met in New York City, has elected the following officers for the ensuing year: Rhodes Stansbury Sutton, of Pennsylvania, President. Lewis P. Bush, of Delaware; S. J. Jones, Illnois; R. Lowry Sibbet, Pennsylvania; Frederick H. Gerrish, Maine, Vice-Presidents. Richard J. Dunglison, Pennsylvania, Secretary and Treasurer. Charles McIntire, Jr., Pennsylvania, Assistant Secretary. The Committee recommended Pittsburg, Pa., as the next place of meeting.

In the future, all persons desiring from the University of Pennsylvania the endorsement on the diploma demanded by Sect. 4, of the Act of 1881, will be required to pass an examination on Chemistry, Anatomy, Physiology, Materia Medica and Therapeutics, Pathology and Morbid Anatomy, Practice of Medicine, Surgery, and on Obstetrics; failure in any branch will cause rejection. To compensate for the labor of such examinations, a fee of $30 will be charged.

Dr. W. B. Griffith, a former practitioner of this city, where he was well-known and highly respected, died in Dakota on November 2d, after a lingering illness. Dr. Griffith was forced to give up his practice on account of ill-health several years ago. He went to Dakota in search of a climate that might prolong his days. We regret to announce his untimely death in the 42d year of his age.

Dr. W. T. Councilman, associate in pathology Johns Hopkins University, will give at Bay-View Asylum a course of weekly demonstrations in gross pathology combined with instruction in making autopsies. All of the pathological material which accumulates during the week will be shown and every opportunity taken of making autopsies before the class. The course will be held every Saturday in the dead house of the Asylum from 2½ to 4 P. M. during the months of November, December, January and February. Fee for the course $10.00.

Dr. A. S. Winchester, a graduate of the University of Maryland, class of 1873, died at his home in Harford County Maryland, on October 26th, in the 34th year of his age. Dr. Winchester was well-known to a number of the readers of this Journal. He was a remarkably genial and pleasant companion during his student days, and gave promise of marked success in his profession. His health became impaired soon after graduation, and he was compelled to relinquish all professional work and was never able to resume it. His death will be regretted by all of his old class-mates who are able to recall the bright, energetic and promising companion of bygone days.

Original Articles.

A FATAL CASE OF FIBROMA OF THE UTERUS.*

BY J. M. ANDERS, M. D., OF PHILA.

On the evening of August 27th, 1885, Mrs. G., aged 46 years, possessing, to all appearances, an admirable physique, called on me for the purpose of obtaining relief from two symptoms, namely, bleeding from the womb, this being almost continuous, and a feeling of general weakness. With the single exception of a somewhat blanched appearance of the face, no other symptoms could at that time be elicited. For these symptoms I prescribed the fluid extract of ergot and the sulphate of quinia, giving both remedies in moderate doses. It should be remarked that the previous history which she gave of her case was about as follows: About one year previous to the date of her visit she had observed her menses to be somewhat profuse, and also the time of their appearance to be somewhat irregular. This state of things existed until about three months prior to the time she presented herself for treatment, when the hemorrhage during her monthly periods became even greater; besides, more or less hemorrhage, excepting when she confined herself to bed, was practically constant. According to her own story, which I had no reason to discredit, the total amount of blood she had already lost must have been considerable, and yet she was not thin in flesh, but, on the contrary, really plump. The treatment above indicated was continued for at least four weeks, and having found the symptoms only slightly improved, it was decided to make a uterine examination, which revealed the following: The posterior lip of the os uteri was considerably everted, thus strongly simulating a lacerated cervix; it, however, was at the same time observed to be greatly elongated, as well as greatly infiltrated. Upon making firm external pressure on the fundus of the organ with my left hand I was, with the forefinger of my right hand, able to distinctly trace the outline of a new growth slightly projecting from the posterior wall into the cavity of the uterus, which growth was similar in shape, and not exceeding in size, the half of a duck's egg longitudinally divided. The diagnosis, based upon the conditions related, of fibroid tumor, chiefly submucous, but, owing to the peculiar condition of the os already described, to some extent interstitial, was made. It might be questioned whether a lacerated cervix did not previously exist; but when it is recalled that for the past fifteen years she had not been pregnant, and that during the long interval between her last pregnancy and the onset of her last illness she had enjoyed excellent health, its presence may be doubted. With the view of decreasing the size of, as well as the amount of bleeding from, the growth, the same remedies in somewhat fuller doses were employed. A solution of tannic acid and glycerine was likewise semi-weekly topically applied. The patient was kept indoors and advised to spend half the day in bed. From this treatment more favorable results were obtained, the size of the growth gradually diminished and the hemorrhage, for the most *part*, ceased. She also felt herself growing stronger. The same line of treatment was persevered in until November 23d, a period of nearly two months, and it should be noted that no symptoms, such as coolness of the extremities, etc., indicating the full physiological effect of the ergot, had up to this time been observed.

On the morning of November 22d her condition was apparently very encouraging. The tumor was about half its original size. Neither was there then, nor had there been for a fortnight, any uterine hemorrhage, and the patient had again been allowed to move into the open air. November 23d marked an unfortunate epoch in her case. She was on that day seized with violent pains which, doubtless, were due to uterine contractions; both ergot and quinine were at once replaced by morphia and bromide of potassium in combination. The follow-

*Read before the Philadelphia County Medical Society, September 16, 1885.

ing morning, November 24th, found her somewhat relieved, but at intervals of a few minutes still suffering great pain. An examination of the tumor plainly showed that the lower portion of it had already undergone softening, and from it escaped a small amount of serous fluid, having a marked odor. At the same time it was equally clear that it had, from some cause or other, become inflamed, being both hot and tender to the touch, and the general signs, elevation of temperature, etc, evidencing the same view. Within the next twenty-four hours she fell into a marked chill, followed by a still greater rise of bodily heat, the thermometer indicating a temperature of 102° Fahr. The abdominal signs consisted of pain on palpation over the uterus and slight tenderness on either side of this organ, the latter symptom pointing to the presence of local peritonitis. The forcing down pains were controlled by the free use of opiates. During the month following the first, not less than half a dozen chills, which, however, were less severe, occurred, and in the same interval of time the temperature was found to range from 99 to 101.5° Fahr. So far as could be ascertained by digital exploration the condition of the tumor remained unchanged, excepting that portion of the fibroma which had previously softened, this being found to be gradually disintegrating and draining away. After January 1st, 1885, gradual improvement, both in the general and local symptoms, set in, and at the end of another month the temperature had returned to the normal, the local abdominal signs had almost entirely disappeared, and the discharge had virtually ceased. Simultaneously with the progress of this happy improvement she had also, in some measure, regained her former strength and flesh, and in consequence of her repeated entreaties to be allowed to sit up, this privilege was granted; but after the second trial the former symptoms of inflammation again appeared, the temperature rapidly rising to 101.5° Fahr., the local signs of pains and tenderness on palpation as well as the serous-like discharge also recurring. Added to this the stomach would now, at times, reject alike food and medicines. Her disease, during the next three weeks, did not show the slighest improvement, but, on the other hand, she grew weaker and notably emaciated. While in this condition, on February 28th, Dr. B. F. Baer was called as consultant. He advised that, should the symptoms of inflammation subside and should sufficient strength return to admit of it, a curette be employed, with a view to remove as much as practicable of the morbid growth, which, on account of becoming to some extent interstitial, was not totally removable. The hope of being enabled to operate was not strengthed by the results of subsequent treatment, which did not appear to benefit her condition in the least. About April 1st she began to be troubled with diarrhœa, which proved to be extremely obstinate, and within a fortnight from its onset partook in great part of the character of dysentery, as shown by the following facts, namely: the stools, besides liquid fæces, consisted of mucus, occasionally tinged with blood, and there was present an almost constant desire to go to stool. In a few days that portion of the abdomen corresponding to the descending colon and rectum became sensitive to the touch, and about the same time the entire abdomen became tympanitic and somewhat swollen. Owing to the fact that her previous disease had already placed her life in great peril, this new complication was looked upon as alarming in the extreme, and Dr. L. Starr was requested to see the patient in consultation. In the back yard of the patient's dwelling was located a cesspool, and from it emanated repugnant odors which could, on warm days when the doors and windows were thrown open, be readily perceived by the senses, throughout the dwelling. Dr. Starr gave it as his opinion that these noxious gases were, perhaps, instrumental in maintaining the bowel difficulty. In the light of the gross character of the lesions found in the intestines at the autopsy subsequently made, this hypothesis could hardly have been tenable. Although the symptoms just narrated, due to the development of the bowel lesions,

varied somewhat in intensity, yet they continued up to the time of her decease, which occurred May 1st. In view of the fact that the treatment during the later stages of the case embraced nothing of special interest, it is not deemed necessary to give an account of it. Forty-eight hours after death an autopsy was made, Dr. Geo. B. Miller assisting. The peritoneum presented evidences of chronic inflammation, and there was a small amount of exuditional matter in its cavity. In size, the womb was about normal, and with the exception of the lower half of the posterior wall of the body and the posterior lip of the os, it was normal in appearance. This portion was occupied by the new growth, which was found to be partly interstitial and forming a light protuberance projecting into the uterine cavity. Its consistence was about the same as that of the sound uterine tissue and it was reduced to less than half its original dimensions. In the pelvic cavity surrounding the uterus not less than five ounces of pus were found. The stomach and small intestines showed nothing abnormal, while the descending colon and rectum were notably diseased. It is no exaggeration to say that the walls of this portion of the intestine were thrice their natural thickness, all the coats being distinctly affected. The serous surface was congested and dusky red in color. The mucous membrane was found to be greatly thickened and presented almost throughout a color much darker than that of the healthy bowel, while in spots it appeared to be really gangrenous. The liver and kidneys were not diseased looking. The thoracic organs were not examined. Unfortunately, the friends of the deceased did not allow us to retain a specimen of the diseased intestines for purposes of further examination. The only specimen we were able to obtain was a small part of that portion of the new growth which protruded into the cavity of the womb, this, as correctly argued by the husband, not really belonging to the body of the deceased.

A microscopical examination of the growth was made by Dr. H. F. Formad, who kindly furnished a statement of the results obtained. He writes: "I made sections of the fragments of new growth you sent me, and find that they show the structure of *Fibroma*, evidently developed from the uterus, as it incorporates some smooth muscular tissue. The latter, however, did not take any active part in the formation of the tumor proper, which is nearly exclusively made up of areolar connective tissue."

Though there is not the slighest reason to question the correctness of the doctor's conclusions, yet his results do not afford conclusive evidence to the effect that the growth was not to some extent interstitial, since specimens examined were taken from the portion projecting into the cavity of the uterus, and not from the wall of the uterus or the os underlying the protuberance formed by the fibroma.

From the extensive character of the morbid changes exhibited by the descending colon and rectum, together with their peculiar nature, it is unquestionable that during life we had to deal with a condition which Cullen has termed phlegmonous enteritis. All medical authors agree that in this affection constipation forms a prominent symptom, though in the present case this symptom, it will be remembered, was replaced by diarrhœa associated with dysentery. The location of the disease may in this instance afford a satisfactory explanation of the fact that in the place of constipation, diarrhœa existed. The disease of the intestine was doubtless caused by extension either from the peritoneal inflammation or the cellulitis, and although the noxious gases arising from the cesspool situated in the yard to the leeward of the dwelling may have exercised some influence upon the symptom of diarrhœa, they could not, in the light of the facts already put forward as the result of the autopsy, be reasonably regarded as causative agencies.

The fact that necrosis of the tumor set in after the condition of the patient had already greatly improved, is worthy of special mention. Whether in this case the death of a part of the tumor was due to the influence of the prolonged

use of the ergot (nearly three months), or to any one of the various hypotheses from time to time brought forward to explain the nature of the process of disintegration which these tumors not unfrequently undergo, cannot, perhaps, be clearly determined. The query, however, whether ergot, through its peculiar action upon the uterine fibre, is capable of producing death of a fibroid growth when similarly situated is one meriting attention on the part of the practising physician, but space forbids its discussion here. A question of still greater moment here naturally arises, namely, what is the proper line of treatment to pursue in cases of like kind? No one, perhaps, will dispute the opinion that operative interference would, at any period after the development of the metritis, with its long train of complications, have hastened the fatal issue. The point here raised being one of the most difficult in the whole domain gynecology, its further discussion is cheerfully left to the expert on diseases of women. As bearing upon the treatment of the case here narrated, it remains to be said that up to the date of the occurrence of the accident which finally carried off the patient, the encouraging progress of the case seemed to justify the expectation that a practical cure would, without surgical aid, eventually be attained.

REPORT OF A CASE OF INSTANTANEOUS DEATH BY LIGHTNING.*

BY HENRY F. FORMAD, M. D., OF PHILA.

WITH SOME OBSERVATIONS ON THE EFFECTS OF LIGHTNING ON THE HUMAN BODY.

BY HENRY BEATES, JR., M. D.

On August 20th, 1885, Dr. Formad was summoned to inquire into the circumstances of the death of Mary R., a mulatto woman, aged 61, resident of West Philadelphia, and said to have been killed by lightning the evening before. Dr. Formad did not, at first, feel convinced that lightning had been operative in causing the death of the woman, because there were no visible marks on the body or evidence of any kind at the locality of occurrence. The testimony, however, of reliable witnesses, and the fact that a severe thunder storm prevailed at the time of her death, supplied confirmatory evidence concerning the alleged cause of destruction of life. The deceased was a robust woman who had always enjoyed excellent health. On the day of the accident she, with her husband, nephew and son, were seated in the order mentioned on a wooden bench, which was placed under a tree. The individual killed was seated on the end approximated to the trunk of the tree. The storm was approaching, and as the rain had not commenced to fall, they remained watching the unusually heavy clouds. Suddenly the flash occurred, instantly killing the woman, rendering temporarily unconscious the nephew, and occasioning a transient anæsthesia of the feet of the husband. The nephew remained totally unconscious for about twenty minutes, and partially conscious for five or six hours, by which time he was thoroughly himself. The only pain experienced was a deeply-seated epigastric, which persisted for forty-eight hours, and headache of one day's duration. The anæsthesia, which was limited to the lower extremities, was pronounced for two days, when it began to ameliorate, and in the course of a week had entirely disappeared. The sphincters escaped and there were no local paralyses. In this case careful examination failed to discover any traces of lightning burn. The husband simply suffered slight numbness of the feet, which lasted for an hour or two and disappeared. Interrogation revealed the fact that the nephew did not experience any pain at the reception of the shock, and the only thing he remembers is his recovery of senses, just as if wakening from a deep sleep, with a loss of power and sensation of extremities, for the cause of which, until the commotion was explained, he possessed no satisfactory solution. The husband experienced a sense of pain accompanying the shock.

*Read before the Philadelphia County Medical Society, September 16, 1885.

REMARKS CONCERNING THE AUTOPSY OF DR. FORMAD'S CASE OF FATAL LIGHTNING STROKE.

The fact that there was total absence of rigor mortis and coagulation is of special interest, as contrary teaching receives the sanction of high authority. Hunter, I believe, is responsible for the assertion that death by lightning is characterized by absence of rigor mortis and coagulation of the blood; a dictum believed and adopted by the profession at large for a number of years, until instances were observed in which the contrary obtained. The contradictory testimony resulted in the institution of an elaborate series of experiments on animals with electricity by means of the Leyden jar. Among the most noteworthy were those of Benjamin W. Richardson, who concluded that rigor mortis and coagulation of the blood constitute in an especial degree the direct effects of fatal shocks of electricity. A review of the fatal cases of lightning stroke discloses the fact that instantaneous death is occasioned, first, without external evidences, secondly, with; the latter consisting of burns, manifesting themselves in different degrees in the same subject; and it is a matter of remark that almost all of those in whom there is wanting external evidence, absence of rigor mortis and organic alterations of the blood, resulting in destruction of its power to coagulate, exist, while when burns, bruises, etc., are present there also is rigor mortis and coagulation. This conclusively demonstrates that the lightning bolt effects its fatal consequences in a diverse manner; one in which the force effects fatal results by direct action upon the centre of the organism, probably, as in the instance reported this evening, by injuring the cerebro-spinal centres; the other by a diffuse process, in which both the exterior and interior are involved. Interesting hypotheses here suggest themselves regarding both the physiological law governing the conditions under consideration, and effects of electricity and the determining powers that occasion its varied effects or distribution of its force. It is asserted by some observers that lightning flash is composed of a potential element and a heat or flame element, and that the different effects are manifest as one or the other predominates. A feature of lightning stroke is that when there are two or three individuals in a group one is usually killed and the others escape with varying degrees of injury. When the bolt is great, one is killed instantaneously while another, as in a case reported in the London *Times*, may be so seriously injured as to die from the secondary effects. A description of the autopsy of such an instance is here quoted. An animal and three men were sheltering from rain under an oak tree. A lighting flash instantly killed one of the men, while the other was rendered unconscious. When consciousness was recovered he was found to be hemiplegic on right side. He lived 9 days, when death ended his sufferings. Autopsy: Abdomen tympanitic, hair of head not singed, while that of the pubes was much burned. It appeared that the lightning entered behind the right ear and passed to right foot, there being a broken line of dark red scars extending between these points. A cut existed at the point of entrance simulating closely that made by a sharp knife. The dark red scars or wheals on the neck were half an inch in breadth, and in some places were characterized by true blisters that had burst. On the chest was a curved line of burn that had evidently been caused by the heated watch chain. From this point a burn about five inches long and two inches wide extend to Poupart's ligament, and was the result of the heated watch burning through the pocket. From inside of right knee to inner malleolus was a broken line of scars about 1½ inches wide. At bend of ankle a scar existed and the skin was broken. Below this point no evidence existed. Upon removal of scalp patches of ecchymoses were found between the layers of the temporal fascia. Over the right side of brain, beneath the dura mater and extending over the middle and posterior lobes, were clots and effused blood. Under these clots the cerebral substance

was softened and easily torn when touched. Throughout the substance blood was effused. The congestion extended to the sulci. The middle meningeal artery was ruptured and the lateral sinus on the right side filled with clots and fibrinous deposits. The right lateral ventricle contained a quantity of bloody serum, and the whole arachnoid membrane was in a condition of opacity, with the vessels conspicuously engorged. Left brain: lateral ventricle filled with a clot an inch broad, which encroached upon the corpus striatum. The corpus striatum, optic thalamus, tænia, semicircularis, roof and walls of ventricle, were so softened that the fall of a gentle stream of water occasioned breaking down. A clot, which was a portion of that in the venticle, was found in the substance of the optic thalamus and impinging upon the crus. The fifth ventricle contained effused bloody serum. Abdomen not examined. The results possess a bearing upon the therapeutic application of electricity, and it is with a hope that the experience of members present may contribute some definite knowledge regarding the conditions which determine specific effects of diverse nature of electricity upon the human body, that the report is submitted for consideration.

Clinical Reports.

CARIES OF THE FEMUR.

Dr. F. P. Hoover, of Washington, D. C., sends a report of the following case:

Susie C., æt. 14 years, white, had suffered from pain in her right leg for six months, when an abscess formed on the side of the leg about eight inches below the lesser trochanter of the femur. It grew larger, and after some weeks broke. From that time there was considerable exudation from it. Child lost flesh. Mother noticed a slight limp, which she supposed to be caused by the great amount of pain when she stood upon that limb. The lameness increased and finally a physician was sent for. After an examination he told the parents an operation had to be performed, which was done a few days later, a free incision being made down the leg, femur scraped and parts united. After sometime another abscess made its appearance about the same spot, which was treated in a like manner as the first, scraping the bone, etc. The second operation after healing resulted in a third abscess being formed in the same spot, according to the mother's statement. About this time the patient came under my care. I enquired into the mother's and father's state of health, the former being a seamstress, the latter a mechanic. Neither had ever complained of being sick. Had four children, two boys and two girls; all of whom were healthy. The sick girl, then 15 years old, was the eldest of the four children. The body was well developed for a girl of that age. Limbs symmetrically formed except the right, which was wasted to about two-thirds the size of the left. Six inches down the thigh was located a running sore, with an opening in it about the size of a five cent piece, exuding pus. The right leg was three quarters of an inch shorter than the left. She experienced no pain when standing, could walk, run errands, etc., without any inconvenience, except having to limp and wear a bandage round her limbs in order to keep her linen clean. Appetite very poor, weight about 20 pounds less than she was before taken sick. Sore occasionally healing and breaking out again. I commenced treatment with the tinct. ferri chloride. gtts. xx three times daily. At the same time I gave her potass. iod., grs. v, three times daily, slowly increasing the dose to grs. x. I also kept the sore open, allowing for free drainage of pus, syringing it out with carbolized warm water every morning, dressing with oakum and bandaging tightly.

Child was under my care for three months. She increased in health, sore gradually healing until it was entirely closed. At this time, at my suggestion, she went out in the country, where she remained three weeks. When she returned she was stout, had rosy cheeks, sore healed, appetite splendid, limped very slightly.

This case was particularly interesting to me, as the amount of shortening was so slight for caries of the femur, the bone having been diseased fully three inches, according to the examination I made with a probe. I saw the girl on the street a month ago, she told me she had not been troubled with her leg since it healed, and did not hurt her in the least upon pressure. It is now eighteen months since I ceased attending her.

Society Reports.

CLINICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD OCT. 23, 1885.

The President, Dr. Edward E. Montgomery, in the chair.

The first paper was the

REPORT OF TWO CASES OF ABORTION, WITH SPECIAL REFERENCE TO THE TREATMENT OF ADHERENT SECUNDINES,

by Dr. Amy S. Barton.

March 7, 1885, I was called hastily to see A. J., a married woman, æt. about 30. The patient was pregnant about four days. Had been suffering with moderate intermittent hemorrhage for twelve weeks. Twelve days before I was called there was an increased flow with escape of the fœtus. A homœopathic physician was called in, who removed a portion of the placenta and said that the remainder was adherent, but would do no harm while the hemorrhage was moderate; if it became violent to send for her; in the meantime the patient might go about as usual. About two P. M. of the day I was called, the hemorrhage did become violent, and the doctor was sent for, only to learn that she had left the city and would not return for a month. In the emergency I was called and reached the patient about 5.30 P. M.; found her exsanguinated; pulse, 130; temp. not taken. Gave brandy by the mouth and hypodermically. Examination per vaginam revealed a patulous os uteri, through which the finger readily passed and appreciated an adherent placenta. This was with some little difficulty removed by means of the finger nail passed forcibly between it and uterine wall. At some points the adhesions were so firm that it was impossible to know where the placenta tissue terminated and the muscular tissue commenced. Consequently, I was obliged to leave a very ragged surface, and I suspected that some threads of placenta remained. The exhaustion of the patient was so great that I did not wash out the uterine cavity, immediately, as is my custom. The next morning temperature, 99°; pulse, 100. I now irrigated the uterine cavity with one pint of warm water, to which was added tinct. iodine, ʒj. This was repeated the next evening, 48 hours after the removal of the placenta; this last injection was followed by about ʒj of fresh blood. There had been no hemorrhage since the operation, and but little lochial discharge. March 9, 1885, temperature, 101.8°; pulse, 116. March 10, 1885, P. M., temperature, 100°; pulse, 112. Patient had a chill half an hour after the last intra-uterine injection, lasting half an hour and followed by fever and perspiration, with abdominal pain. At this date (March 10th) there was slight abdominal tenderness on the right side. Tongue clean. I made an application of pure tincture of iodine to the uterine cavity, by means of cotton and dressing forceps, and kept a pledget saturated with warm glycerine in the vagina. The mammary glands were painful, as the lacteal secretion had been established. Ordered quiniæ sulph., grs. ii, every four hours. At 4 P. M. temperature rose to 102.3°; pulse, 112. Gave grs. vj quin. sulph. at bed-time. Next morning (11th inst.) temperature 99°; pulse, 98. Above which point temperature did not rise afterwards. I discharged the patient on the 17th inst. Temperature, 98.8°; pulse, 90.

March 6, 1884, I saw for the first time F. W., æt. 30; married; mother of one child, five years old. On entering the living room of the house I was met by my patient, a woman of slight figure, pale, emaciated and tremulous, who was evidently scarcely able to stand alone,

yet she was dressed and down stairs. The peculiar pallor and pinched expression of the features suggested blood-poisoning. Temperature, 102°; pulse, 80; abdomen tender and tympanitic. Proceeding the history of the case, I learned that the patient had had a miscarriage three weeks previously, preceded by moderate hemorrhage for three or four days. The family physician being called in removed the contents of the uterus, after which the flow stopped, but the patient did not rally. According to her statement she had fever with abdominal pain and tenderness. Becoming discouraged she had discharged the attending physician one week before calling me. He then advised her to "get about" and she would probably regain her strength. This she had faithfully tried to do; being carried down stairs in the morning, she remained propped back in an easy chair, supported by pillows, until night, when her husband carried her back to her chamber. She, however, grew worse. Vaginal examination disclosed great swelling and tenderness of the peri-uterine tissues, the vaginal roof being bulged downward, though no distinct fluctuation could be felt. Neither was there any discharge or odor from the cervix uteri, which was fixed and not patulous. While I suspected that a portion of the placenta had been retained and was the cause of the mischief, I did not deem it justifiable to explore the uterine cavity at this late date since there was positive evidence of pelvic cellulitis. I ordered the patient to go to bed, to have hot vaginal douches, turpentine stupes, quinia and opium. The temperature fell irregularly until on the 16th, inst. it was 99.6° with a pulse of 100.7. On the 17th, temperature 102°. In the morning, pulse 106. 18th, P. M. temperature, 100°, pulse, 97. By the 21st inst. temperature had fallen to 99.4°, pulse, 96. On the 22nd, temperature went abruptly up to 102° again, pulse, 106. So it fluctuated, going down to normal April 3rd, and varying from this to 102° above which point it did not rise until May 3rd, when it reached 104°, pulse, 120. During the greater part of this time there was persistent nausea and frequent vomiting which greatly interferred with administration of nourishment. Medicines had to be given by the rectum, and hypodermically much of the time. The tympanites and abdominal pain were extreme, requiring hypodermic administrations of morphia to give relief. Coïncident with the rise of temperature, May 3rd, an enlargement appeared just below Poupart's ligament. It soon became apparent that an abscess was forming at this point, though no fluctuation could be detected either here or in the vaginal roof. In the course of a few days another point of suppuration appeared in Scarpa's triangle evidently continuous with the first.

On the 13th inst. fluctuation appeared, I opened the lower abscess and evacuated a small amount of pus, I then washed out the cavity with a solution of hydrarg. bichlor. 1 to 3,000, and left a drainage tube in situ. At the time of the operation temperature, 100.6°; pulse, 120.

May 14th, P. M., temperature, 97.70°; pulse, 100. May 15, P. M. temperature, 98.4°; pulse, 86. Temperature fluctuated from normal to 100.4°, the point marked on the evening of May 21st, after which I was unable to see the case and Dr. Hanna T. Croasdale kindly took charge of it for me. From the time of lancing the abscess until it ceased to discharge, the cavity was irrigated, at first daily, and later at less frequent intervals, with the bichloride solution. The patient convalesced very slowly and was not able to leave the city until the last of June, *four* months after I took charge of her and *five* months after the miscarriage. She then went to Atlantic City and remained until late in the Fall, when she returned looking well and in good flesh. She is still quite lame in the left limb. The treatment from the first was supporting and stimulating, with opium, as required to relieve pain and gr. $\frac{1}{24}$ of bichloride of mercury three times a day, as long as the stomach could tolerate it. Local treatment consisted in hot fomentations, alternated with inunctions of mecurial and belladonna ointment, and hot vaginal douches.

After attending this lady about two weeks I asked for counsel and the physician who was first in attendance was called in. He agreed with me that it was a case of septicæmia, due to retained placenta. He said that when he delivered the placenta he knew that he had left a piece of it in the uterine cavity, but thought it safer to let it remain and trust to nature to throw it off, than to introduce his finger and thereby expose his patient to the danger of poisoning from without. In the management of this case the doctor is supported by many eminent in the profession; though the tendency in later years is decidedly in favor of complete removal of the secundines. Yet so recently as in the Sept. 1885 No. of *American Journal of Obstetrics*, there is an article by Dr. G. R. Southwick, of Boston, in which he advocates conservative treatment unless urgent symptoms be present. He says: "There are few physicians who have not attended a case of abortion, with retained secundines, plugged the vagina, and on removing the plug, a few hours later, found the secundines expelled behind it. This is indeed the rule, and is it not better than to make the patient undergo a painful operation attended with a certain amount of risk? It sounds very easy to *read* that to remove the adherent placenta the uterus is to be pressed down in the pelvis with one hand externally, while the forefinger of the other enters the uterine cavity, passes up over one side of the placenta and down on the other so as to hook it down and extract it from the uterus. As a rule there is only partial separation, the blood-vessels are ruptured, the uterus cannot contract to advantage and the hemorrhage is worse, or else a considerable amount of blood is lost before the object is accomplished." That the operation of detaching an adherent placenta, with the finger is more difficult than it sounds, I freely admit, but I cannot agree with Dr. Southwick in believing that it is possible only in rare cases. If the parts are so rigid that the finger cannot be made to penetrate the uterine cavity sufficiently to reach the upper portion of the placenta, etherization will overcome the difficulty in the majority of cases. If the placenta be removed entirely, I have always found the uterus to contract at once and thus stop all hemorrhage. This I believe is partially due to the irritation caused by the forcible detachment. The danger of contagion from without can be prevented by thoroughly irrigating the uterine cavity with hot water, 120°, containing some antiseptic. This is also one of the best hæmospastics. I have not yet seen any bad results follow this plan of treatment, but I have met with numerous examples of inflammatory reaction in blood-poisoning resulting from expectant treatment.

In the discussion which followed the reading of the paper:

Dr. Hanna T. Croasdale said that the more she saw of such cases the more fully was she convinced that as long as any portion of the placenta remained *just so long* was the patient in danger of hemorrhage or septicæmia or both. She thought it easier in hospital practice to remove adherent secundines than in private practice; it is difficult to convince the party of the necessity for removal and they are apt to look upon the necessary manipulations as being productive of danger.

Dr. Collins considers that these cases come under the domain of antiseptic surgery. It is his object in attending a case where the secundines are adherent to get rid of every fragment as soon as possible. He has always found this plan to succeed better than waiting; after removal of the secundines he orders douches of hydrarg. bichlor. or potass. permanganate. Septicæmia will take place when absorption occurs; try to leave nothing to be absorbed and there will be no danger.

Dr. W. H. Warder said that as a rule he etherizes the patient and removes the placenta. In his early years of practice he sometimes left the secundines after abortion until the uterus threw them off, but after one or two unpleasant experiences he has adopted the present plan. He had seen one case of retained placenta treated by having persulphate of iron thrown into the uterine cavity; in a few days contraction came on and the mass

was expelled. He sometimes uses the uterine sound, heading it so as to hook it over the mass. He generally introduces the speculum so as to expose the cervix uteri, then he dilates the os with forceps, and often the mass will be seen at the os and can be caught in the forceps and removed. Very often the mass can be removed by hooking the index finger over it, the fundus being pressed low down into the pelvis with the other hand.

Dr. John B. Roberts said that he should be much less afraid of judicious manipulation giving trouble than of leaving tissue in the uterine cavity to decompose.

Dr. Edward E. Montgomery said that there were cases where a woman *supposed* she had had an abortion, and on examination the uterus would be found simply contracted; to him it seemed hardly wise to resort to very severe measures in such cases; the uterus will hardly allow any loose body to remain in it without making some attempt to throw it off. His plan in such cases is to place the patient in Sims' position, clean out the vagina with bichloride solution, pack the cervix with cotton, then pack the vagina—this stimulates the uterus to contraction, and in that way the mass is expelled. Where the uterus is dilated more active measures should be used.

Dr. R. Victoria Scott considers that we should have the idea of preventing septic poisoning before us in all of our obstetric work. At the American Gynecological Association an antiseptic pad was presented—a piece of cotton 6 or 8 inches long by 4 inches wide, saturated with bichloride solution, 1 to 3000; outside of this a piece of flannel and over all oiled silk. This is put to the vulva as soon as the patient is delivered. In private practice it should be changed three times a day, and more frequently in hospital practice. Dr. Southwick, of Boston, said that since this pad had been used in the General Hospital of that city there had been no cases of puerperal fever, and, indeed, scarcely any case with a rise of temperature on the third day.

Dr. E. E. Montgomery said that the same pad had been used in the wards of the Philadelphia Hospital about one year ago. Puerperal fever had been epidemic there, but there were no cases during the time the pad was used.

Dr. Amy S. Barton in closing the discussion said that she could not understand how an antiseptic pad would prevent septicæmia if the trouble were in the uterine cavity.

Dr. W. H. Warder then presented a specimen of

CYSTIC TUMOR OF THE OVARY

which had been removed the day before. "The patient was 22 years of age. Menstruation commenced at the age of 17; the function had never been regular, occuring at intervals of three and four months, or even longer. When I saw her she had not menstruated for a year and four months before coming under my care she noticed a slight swelling on the right side; it increased rapidly in size, and on examination, I found a solid resistent tumor, reaching from the pubes to midway between the umbilcus and ensiform cartilage. On vaginal examination the growth was apparently so adherent to the uterus that no separation could be felt between them. Douglas' cul-de sac was entirely filled by a hard firm mass; no fluctuation could be felt either there or over the abdomen. That fact led me to diagnosticate a *fibroid*, notwithstanding the fact that fibroids grow slowly, and that the growth of this tumor had been very rapid. The absence of the catamenia for a year seemed to indicate that the growth was ovarian and that was my first thought. At the time of the operation the pearly white appearance of the ovarian cyst was seen as soon as the peritoneum was incised. The cyst was multilocular, innumerable small cysts being within the sac; indeed it looked as though every follicle in the ovary had undergone *cystic degeneration*. There were no adhesions between the sac and any of the abdominal or pelvic vicera. The patient has done well since the operation. Highest temperature 99°. In the discussion which this specimen brought up, Dr. John B Roberts said there are two causes

for absence of fluctuation: 1. Daughter cysts filling the cavity of a larger cyst. 2. Thick gelatinous, or even serous fluid filling a simple sac so tensely that the sac becomes hard and fluctuation impossible. He had seen, in consultation, a case, which, at first he thought not to be an ovarian tumor, on account of a hard nodule in one part of the abdomen in which no sense of fluctuation was present. The case really seemed more like a uterine fiboid or carcinoma of omentum with ascites. Two weeks later another examination was made by him and some of the fluid drawn off by aspiration, and the growth was then considered to be an ovarian cyst. Later ovariotomy was performed by Dr. Roberts, and a multi-locular cyst was removed. In that part corresponding to the hard nodule there was a tensely filled cyst containing dense gelatinous fluid, which rendered the sac hard by reason of the greatly distended and tensely filled cyst walls.

Dr. Edward E. Montgomery said that this case would show the necessity of exploratory incision when in doubt as to diagnosis. He had seen the case with Dr. Warder, and fully appreciated the hard firm tumor and its apparent attachment to the uterns.

Dr. John B. Roberts stated that he had recently been requested to see, in consultation, a woman who had an abdominal enlargement. The history given was, that a number of months previously the abdomen had become distended and gradually increased in size. On two occasions, however, it had become almost or quite normal in appearance after a severe watery diarrhœa, accompanied by great general prostration. After these attacks the abdomen has each time gradually become distended to about its former size. Vomiting occurred during one of the attacks of diarrhœa, and once after recovery a small mass could be felt in the left side of the abdomen. When the patient was visited by Dr. Roberts she showed the ordinary evidences of a well-marked ovarian cyst of moderate bulk, and operation was advised. Dr. R. expected to perform ovariotony, or at least exploratory laparotomy, as soon as the patient had obtained the requisite courage. He mentioned another case with a similar history concerning which he had been consulted by letter, but which he had never had an opportunity to examine personally. The experience of the members was asked regarding evacuation of ovarian cysts through spontaneous openings into the bowel or into the abdominal wall.

Dr. Hanna T. Croasdale mentioned a case, which has already been reported in full by Dr. Anna E. Broomall. The patient noticed that she did not regain her normal size after prenancy. She became pregnant again, which fact was questioned; after delivery the attending physician, Dr. Robinson of Salem, N. J., diagnosticated a tumor and recommended the patient to go to the Womans' Hospital of Philadelphia. Shortly before her admission she took a cathartic, which induced large watery evacuations, of a chocolate color, which caused a great diminution in the size of the tumor. On admission to the Hospital she complained of pain on the left side; on that side there was an enlargement which became more apparent as emaciation progressed. At the autopsy an ovarian cyst was found, the sac of which was adherent to the colon, and in the sac was found some fecal matter.

Dr. Anita E. Tyng reported a case of ovarian tumor on which she had operated; two days before the operation the patient had a profuse watery evacuation from the bowels, after which the abdomen flattened. At the operation a unilocular cyst was found, which was adherent to the whole colon, so *closely adherent* to the sigmoid flexure that separation was impossible. The patient died from the effects of the operation.

Dr. Tyng mentioned another case of tumor diagnosed as ovarian, which the patient said discharged externally through the abdominal walls; after which there was no visible tumor. The patient's health improved greatly after the discharge. The sac refilled and emptied in this way a number of times. The patient finally succumbed to the effects of the tumor.

Dr. Edward E. Montgomery some years ago saw a specimen of a cyst of

claims to have secured better results by the following method than any previously tried. "The two best salts of quinine to use," he says, "are the bisulphate and hydrochlorate. Both are fairly soluble without acids, but the bisulphate has the advantage of being considerably the cheaper. One grain of that salt will dissolve readily in six minims of equal parts of the purest glycerine and of distilled water at the temperature of the body, and when thrown, at that temperature, into the looser subcutaneous cellular tissue—the only part into which quinine should be injected—will be rapidly absorbed without deposition of any crystals of the drug. To this solution, two per cent. of pure carbolic acid must be added. Thirty minims of such a solution, containing five grains of the bisulphate, may then be used for one injection from a syringe of double the average capacity—now, as rule, just about fifteen minims; and although it is probably better, as previously mentioned, to inject less at one point, no local or general injurious results have followed the numerous applications of the maximum quantity stated, which have been since I have been in the habit of adding the carbolic acid to the diluted glycerine solution of the quinine. The local anæsthetic action of the carbolic acid, too, is unquestionably of great value in diminishing the pain attending the hypodermic use of such an irritating medicine as quinine."

The Induction of Premature Labor in Eclampsia.—Since the various modern methods of inducing premature labor have been brought into practice the arguments against this procedure are not urged with such force as in former times. In fact the induction of premature labor is regarded by all of the best obstetric authorities not only as a legitimate but as a necessary procedure when the indications calling for its practice are clearly present. Indeed, it seems to us that the obstetrician who fails to recognize the value of this procedure in certain cases, and therefore fails to practice the operation in the interest of both mother and child is at fault, and is robbing his patients of an intelligent measure of relief. The operation is one which has been performed for a long time, the first recorded case dating back to 1738. It does not seem to have made much headway, for as late as 1827 it was formerly protested against by the French Academy. In 1831 Prof. Stoltz performed it for the first time in France. It has been severely criticised by the older obstetricians; to which fact we must refer its tardy adoption into general practice. At the present day there is a certain amount of prejudice and dread surrounding the operation, but, if all the facts which call for its use are considered with care there, is no procedure in obstetric practice which promises more to both mother and child.

There are a number of conditions which clearly demand the induction of premature labor, such for example as moderate degrees of pelvic contraction, habitual death of the fœtus, and those diseases which imperil the life of the mother. We shall not consider the induction of premature labor in all of these conditions, but will confine our remarks to the indications calling for its practice in eclampsia.

It has been clearly shown that eclampsia is dependent upon gestation. The question therefore arises in every case of eclampsia whether gestation shall be interrupted. This question is frequently solved by nature, for in a certain number of cases labor comes on spontaneously, thus illustrating the fact that the abortion is a conservative process intended to relieve the system of an overtaxed condition. When abortions take place in a spontaneous way the strain upon the patient's nervous system is frequently relieved and the convulsive action ceases. Whilst premature delivery, thus induced by the spontaneous efforts of nature, exercises a most favorable influence upon the nervous tension, which is a cause of the convulsive seizures, it is a well-known fact that nature is often too slow in her action and does not play her rôle as promptly as the safety of the patient demands. She gives the physician a clue to the most rational course of treatment in a certain number of cases

without actually performing her duty. It then clearly becomes the duty of the obstetrician to carry into effect the temporizing policy before the opportunity of rescuing the patient from imminent peril may escape. We, therefore, think that in the policy which nature indicates, but does not always carry into effect, we have a most valuable and reliable suggestion as to the true course of treatment to be adopted in puerperal eclampsia. We do not by any means intend to lay down the broad statement that the induction of premature labor should be practiced in every case of eclampsia. On the contrary, we would insist upon the gravity of this procedure and advocate its postponement until all other methods of treatment have been carefully tried. When these have failed to ward off the impending danger, it then clearly becomes the duty of the obstetrician to employ the most natural means of averting the death of both mother and child. The induction of premature labor is not undertaken solely in the interest of the mother, still it presents to her a better promise of recovery than any other plan of treatment which has been suggested when she is threatened with permanent damage to her kidneys. After gestation has reached seven months the procedure is clearly indicated in the interest of the child, and it should not be postponed until the mother is nearly moribund before it is practiced. The interest of the child is closely linked to that of the mother, and the postponement of operative interference is almost sure to result unfavorably to both. This is especially true if the operation is deferred until the mother's system is profoundly saturated with uræmic poison. In considering the gravity of the conditions which call for the induction of premature labor in eclampsia the obstetrician should not lose sight of the fact that the convulsive seizures may be controlled by agents which quiet nervous tension without modifying the strain upon the kidneys. Thus for example, the patient may pass through the nervous phenomena until relieved by natural labor and yet have inflicted upon her kidneys and eyes such lesions as may lay the foundation for permanent disease. It cannot be questioned that a premature labor is clearly the proper method of treatment to be employed in these conditions. The procedure is not attended with such grave results as those which will follow from permanently damaged organs.

The shock attending the operation for the induction of premature labor has been urged as an argument against its practice. In our opinion this condition has been unduly exaggerated. Statistics do not show that the shock of the procedure is as unfavorable to the condition of the mother as the procrastination until her powers are worn out by repeated convulsive seizures and profound toxæmia.

Reviews, Books and Pamphlets.

A System of Practical Medicine. By American Authors. Edited by Wm. Pepper, M. D., LL.D., assisted by Louis Starr, M. D. Volume III. Diseases of the Respiratory, Circulatory, and Hæmatopoietic Systems. Philadelphia: Lea Brothers & Co. 1885. Pp. 981.

The third volume of this valuable work is devoted to the consideration of Diseases of the Respiratory, Circulatory, and Hæmatopoietic Systems. The volume opens with an admirably prepared chapter on Laryngoscopy and Rhinoscopy from the pen of Dr. Carl Seiler. This is followed by a chapter on the Diseases of the Nasal Passages by Dr. Harrison Allen. The various Diseases of the Larynx and Trachea are discussed by gentlemen well-known in these specialties. The late Dr. Louis Elsberg has contributed two articles, one on Diseases of the Larynx and the other on Diseases of the Trachea. These are perhaps the last contributions from the pen of this gifted author and much lamented physician.

Four articles articles are contributed by Dr. S. C. Chew, of this city, entitled Dilatation of the Bronchial Tubes, Circumscribed and Diffused; Emphysema; Collapse of the Lung (Atelectasis), and Congestion and Œdema of the Lungs (Hypostatic Pneumonia). These articles

are written in this writer's well-known chaste and lucid style, and they present a clear, practical and valuable elucidation of the subjects treated.

Croupous Pneumonia is the title of an article from the pen of Dr. A. L. Loomis, whilst Dr. William Pepper discusses the subject of Catarrhal Pneumonia.

An article on Pulmonary Phthisis (Fibroid Phthisis or Chronic Interstitial Pneumonia) is carefully and elaborately treated by Dr. Austin Flint. The subject of Acute Miliary Tuberculosis is the title of a contribution from the pen of Dr. John S. Lynch, of this city, presented with some condensation, but in a clear and judicious style. The next article, and the last in the series of the Diseases of the Respiratory System, is an exhaustive and elaborate contribution to the study of the Diseases of the Pleura from the pen of Dr. Frank Donaldson, of this city. Dr. Donaldson occupies no less than 115 pages of this volume with a thorough and most valuable presentation of the subjects considered. He has shown in this article great care and ability as an author, and we much doubt whether there is in the language a more able treatise on the diseases of the pleura than the one he has presented in this volume.

The Diseases of the Circulatory System occupy 260 pages. The subjects are well-selected and have been prepared by well-known authorities. The Diseases of the Blood and of the Hæmatopoietic System take up the remaining 111 pages of the volume. Diseases of the Blood and the Blood-Glandular System is the title of an elaborate article from the pen of Dr. Wm. Osler. Diseases of the Spleen are fully and very carefully presented by Dr. I. E. Atkinson, of this city. Diseases of the Thyroid Gland are discussed by Dr. D. Hayes Agnew, and the volume closes with an article on Simple Lymphangitis from the pen of Dr. S. C. Busey.

The volume as a whole comes fully up to the standard of the two volumes previously issued.

How to Use Listerine. Prepared by the Lambert Chemical Company. St. Louis, Mo. 1885. Pp. 32.

The field of antiseptic medication has become so broadened by the demands of the present day that numerous antiseptic agents have been brought into prominence by commercial houses and manufacturing chemists. Among these agents Listerine has become thoroughly familiar to every student of medical literature, and has made for itself a permanent place in professional regard as a useful and safe antiseptic for both local and internal use. Listerine does not claim to be a germicide or disinfectant for cesspools, drains or closets; but it has a strong position as a superior antiseptic for local application to diseased surfaces. The testimonials offered in confirmation of its superior antiseptic value come from the very best-known men in the profession. The Lambert Chemical Company have maintained the highest standard for Listerine from its first conception, not only in its manufacture, but in a strictly professional and scientific method of introduction. Their methods of dealing with the profession are worthy of commendation, The present little work is simply a compilation of suggestions based upon clinical experience, which are offered in no arbitary sense. The work will be mailed *gratis* to any physician upon application to the Company.

Practical Therapeutics; a Compilation of Selected Formulæ and Practical Hints of Treatment. Systematically Arranged, Interleaved, and Copiously Indexed. By Edward J. Bermingham, A. M., M. D., Fellow and Ex-Vice-President of the American Academy of Medicine, etc. New York: J. R. Bermingham, Publisher. 1885. Pp. 405.

This work is a compilation of selected formulæ and practical hints on the treatment of various diseases. The formulæ have been taken from the works of well-known medical writers and teachers, and have been arranged under suitable headings so as to be readily used by those who desire a stereotyped perscription for treating a given complaint.

Many of these formulæ, are thoroughly trustworthy, but we cannot altogether approve of a system of prescribing for diseases by fixed and arbitrary prescriptions, many of which are only useful in a very limited number of conditions. The practitioner may, however, find in the book a number of valuable suggestions, which will prove of service in certain cases. Many of the formulæ will suggest new methods of combining remedies in convenient and palatable forms for ready use, and a certain number of them may be used to advantage in the form in which they are printed. The selections have been judicously made by the editor. The book is interlined with blank pages intended to be used for copying such other formulæ as the owner of the work may gather from other sources.

A Text Book of Physiology. By M. Foster, M. A., M. D., F. R. S. Third American from the Fourth and Revised English Edition. With Extensive Notes and Additions. By Edward T. Reichert, M. D. Philadelphia: Lee Brothers & Co. 1885. Pp. 893.

This well-known work has now become so familiar to the American students of Physiology that a mere reference to its many excellent features is all that is required at our hands. The third American edition has been issued by the publishers during the present year. In this edition numerous corrections and alterations appear, all of which are designed to add to its usefulness by presenting the very latest developments in physiological science.

Post-mortem Examinations, with Especial References to the Medico-Legal Practice. By Prof. Rudolph Virchow, of the Berlin Charité Hospital. Translated by T. P. Smith, M. D., M. R. S., with Additional Notes and New Plates. From the Fourth German Edition. Philadelphia: P. Blackiston, Son & Co. 1885. Pp. 138. Price, $1.00.

Prof. Virchow's well-known book on post-mortem examinations has been in the hands of the profession for a number of years. The present volume is a translation of the fourth German edition, to which have been added additional notes and new plates by the translator. The work has a value to every medical practitioner, and should have a place upon his library shelf.

Miscellany.

A Remarkable Case of Ascites.—Dr. William A. McDonald, of Lynn, Mass., reports in the *Medical Record*, the case of a woman, about fifty years of age, who came under his care in December, 1880, suffering from an accumulation of fluid in the peritoneal cavity. She stated that the abdomen had been tapped six weeks before, while she was living in the West. Dr. McDonald introduced the aspirator needle and drew off twenty-two quarts of fluid, and from that time until the present the operation has been repeated at intervals of about two weeks, from sixteen to twenty quarts being removed each time. Examination of the urine failed to reveal any cause for the ascites, and neither the liver nor the heart presented any symptoms of disease. Medicinal treatment was ineffectual in preventing the exudation or in promoting its absorption. The patient has now furnished about five hundred gallons of fluid, but seems to have suffered in no way from this abnormal excretion, her general condition presenting no change save that incidental to increasing years.

A Florida Medical Journal.—It is announced that the first number of a monthly journal of sixty pages, to be styled the "Florida Medical and Surgical Journal," will be published at Jacksonville, on the 1st of November. It is to be edited by Dr. T. O. Summers, Dr. C. H. Mallett, and Dr. Neal Mitchell, who promise that no efforts will be spared to make it "a faithful exponent of the highest interests of the profession throughout the State." A feature of the journal, and one that can be made very valuable, is to be the supplying of information concerning the influence of the Peninsular climate.—*N. Y. Med. Jl.*

Treatment of Lacerations of the Os and Cervix Uteri Without Surgical Operation.—Dr. Bedford Brown, of Alexandria, read a paper before the Medical Society of Virginia, at its recent meeting, on the above subject. While admitting the advantages of Emmet's operation as a prompt means of relief, though not unattended with danger, there were yet many females, the author said, who were debarred from these benefits and for whom some other method, or none at all must be used. During the past twelve years the writer had treated successfully upward of twenty cases of laceration and fissure of the os and cervix, of varying degrees of severity and some complicated with cellulitis, displacements, subinvolution, etc., by means of local applications alone. The patients suffered from severe neuralgic pains, and in most of them there was more or less impairment of the general health. The writer had seen several cases of laceration in the acute stage heal by first intention after the enforcement of absolute rest and the carrying out of measures of strict cleanliness and disinfection. Warm douches containing borax, boracic acid, and carbolic acid were used gently two or three times a day. If the lacerations did not heal within two weeks they would not heal at all by first intention. In the treatment of old lesions the author had obtained the best results with graduated solutions of nitrate of silver. He applied a solution of thirty grains to the ounce freely to the interior of the cervical canal, and another of fifty grains to the ounce was painted over the whole external surface of the os and cervix until a uniform thick white coating was formed. This coating protects the exposed nerve-filaments, allays inflammation, stimulates the growth of healthy granulations and prevents the absorption of septic matters from the discharges. The solution should be made to penetrate to the very bottom of the fissure in order to ensure success. If hypertrophy and induration of the cervix remain after the lacerations are healed, an application to the external surface is made of a solution of nitrate of silver, 3 ij. to ℥j. Several of the patients thus treated became pregnant, whereas while the disease existed they were sterile, and being examined after the birth of their children, the cervix and os were found in every case to be normal and entirely free from disease. —*Med. Record.*

Pasteur's Experiments in Hydrophobia.—A boy, 12 years of age, named Meister, who had been bitten fourteen times, came from Alsace with his mother to see Dr. Pasteur. The autopsy of the dog which had bitten the boy left no doubt as to its having suffered from hydrophobia. Dr. Pasteur took the celebrated Dr. Vulpian and a Professor of the School of Medicine to see the boy Meister. These two doctors came to the conclusion that the boy was doomed to a painful death and might be experimented upon. In thirteen days inoculations were made upon Meister with pieces of spinal marrow containing virus of constantly increasing strength, the last being from the spine of a rabbit that died only the day before. Now a hundred days have passed since Meister underwent the last inoculation. The treatment has been thoroughly successful, and the boy is in perfect health. He had been bitten sixteen hours, and had travelled from Alsace to Paris before the first inoculation was performed.—*Med. News.*

Beef Powder in the Treatment of Simple Ulcer of the Stomach.—Under the inspiration of M. Debove, M. A. L. Pradet has written a work on the treatment of simple ulcer of the stomach, in which, as we learn from a review in "Union médicale," he recommends the use of a mixture of beef-powder and bicarbonate of sodium. Small doses, he says, should be used for the first two days, but afterward 1,500 grains of beef powder (*poudre de viande*) and 450 grains of bicarbonate of sodium may be given daily to a man, and 1,125 grains of beef powder and 360 grains of the sodium salt to a woman. The treatment should be pursued until complete recovery has taken place, and it is only with extreme carefulness that the patient should be allowed to resume the use of ordinary food.—*N. Y. Med. Journal.*

Poisoning by Chloroform Internally Administered.—Dr. J. M. Latta, of Millerton, Kan., reports to the *Medical Record*, the case of a boy, six years of age, suffering from tape-worm, for whom he ordered a mixture of one part chloroform in three parts simple syrup, of which one teaspoonful was to be given every hour until four doses had been taken. By mistake the parents gave the mixture in tablespoonful doses. Twenty minutes after he had taken the fourth dose of the mixture the boy said the medicine was "about to kill him;" he reeled like a drunken person and vomited violently, throwing up mucus tinged with blood. The child was rational when first seen by Dr. Latta, and said that his stomach hurt him, but in a few minutes he became unconscious. The pupils were normal, the breathing easy, and the pulse a little accelerated but regular, and rather full and bounding. The face was covered with an even red flush, arterial in tint. The temperature was not taken. It was impossible to arouse the boy by calling or shaking him. All the pillows were removed, the body was placed straight and all constricted portions of clothing loosened, and fresh air was freely admitted into the room. The pulse and respiration were carefully watched, but as they furnished no special indications for treatment, nothing more was done. The pulse became gradually less rapid, the flush disappeared from the face, and in an hour and a half the boy awoke and expressed himself as being all right. A saline was administered a few hours later and the bowels were moved, but there was no appearance of any tape-worm.

Injection of a New Preparation of Albuminate of Mercury in Syphilis.—Dr. Max Kockhart, of Wiesbaden, describes, in a German dermatological journal, an ingenious method of administering mercury in syphilitic cases by subcutaneous injection, which, he says, is perfectly innocuous, never having caused pain, induration, or abscess. He combines the mercury with blood-serum. The latter, which may be obtained from the horse, sheep, or ox, is sterilised according to Koch's process, and then filtered. Of the filtrate, 40 cubic centimètres is poured into a graduated glass. To this is added a warm (50° Cent.) solution of 3 grammes of bichloride of mercury, in 30 grammes of water. The resulting precipitate is dissolved in a solution of 7 grammes of common salt in 20 grammes of water. This gives a 3 per cent. solution of mercury blood-serum. This is then mixed with distilled water, so that the whole weighs 200 grammes, which reduces the strength to 1¼ per cent., which is the best strength for use; a gramme of it containing 0.015 gramme of mercurial albuminate. This solution is a yellowish opalescent liquid, with neutral reaction, and will keep very well in a dark glass bottle in a cool place. The injections are given once or twice a day, 0.7 gramme being introduced on each occasion, containing about 0.01 gramme, or three-twentieths of a grain, of albuminate of mercury. Besides acting rapidly and powerfully on syphilis and keeping the system for a long period free from secondary symptoms, this preparation has the advantage of being staple, cheap, and easily prepared.—*Br. Med. Jour.*

Notice to Oculists and Publishers on Oculistic Matters.—Having taken charge of reporting for the "*Revue Générale d' Ophthalmologie*," edited by Dr. E. Meyer, of Paris, and Dr. Dor, of Lyon, on the progress of Ophthalmology in our country, I beg leave to request all authors and publishers of ophthalmic works and papers to send me copies or reprints of their respective publications, in order to enable me to give the most complete review of the current ophthalmic literature of our country in a periodical of the largest circulation among our profession. (Medical papers please copy.)

Dr. M. Landesberg,
40 W. 34th St., New York.

Small-pox continues to rage with great violence in Canada and a few cases have appeared in the United States, at Lowell, Mass. and St. Paul, Minn.

Medical Items.

The *Medical Record* says the number of medical students in New York city is larger this winter than ever before. The same statement holds good for Baltimore. The wonder is where they all come from.

The *British Medical Journal* says: "In order to prevent the introduction of syphilis into their homes, the reserve men of the Russian army, before being dismissed, are to be examined, and, if necessary, detained in hospital until it is safe to allow them to return home."

Dr. Samuel W. Francis, of Newport, R. I., reports a case of ventral hernia in which the measurements for a truss were as follows: circumference at the top, 41 inches; at the middle, 55 inches; at the bottom, 50 inches; length from above downward, 24 inches.—*Med. Record.*

It is rumored that Detroit, Mich., is to have another Medical College in the near future. Florida recently gave birth to a medical Faculty, and a college has been organized in that state. It is about time for Alaska, Greenland, or some other frozen land to organize a medical Faculty and offer special inducements in the medical educational line.

The *Medical Times and Gazette* states that the Harvey manuscript lectures are soon to be published in the form of a photographic reproduction of the author's handwriting, interleaved with a transcript in type. The photographic work has been so successful that many of the passages are more legible in the fac simile than in the original.

The Danish Name for It.—In several notices which have appeared of late in the *Hospitals-Tidende*, concerning the next meeting of the International Medical Congress, and the causes which seem destined to prevent its being held in this country, mention is constantly made of the American med. ass., Am. med. ass., A. m. ass. Why does the organ not protest against such levity?—*Medical Record.*

M. G. Delanay, in a recent communication to the London Biological Society, made the observation that medicine as practised by animals is thoroughly empirical, and the best he could say was practised in the same way by inferior human races or, in other words, by the majority of the human species. In fact, he said, man may take a lesson from the lower animals in hygiene.

According to a report made to a Georgia State Medical Society, there are in that State three towns with a population of over 1,000 each, having no physician. Evelyn, population 1,500, Aerial, population 1,200, and Fouche, population 1,000, are the towns referred to. While there is on an average one physician to 600 people in the United States, Macon, Ga., with a population of 23,000, has but twenty-four physicians, and Savannah, with a population of 41,000, has only thirty-five doctors.—*Ex.*

A Cow with a Wooden Leg.—The *London Medical Record* tells us that Mr. Snarry, an English veterinary surgeon, has accomplished a novel feat in the way of surgery. A cow broke its leg, and there being no chance of reducing the fracture, the limb was amputated, and Mr. Snarry tried the experiment of affixing a wooden leg. This has been found to answer admirably, and the cow may be seen grazing, with a calf by its side.—*Med. and Surg. Reporter.*

New York, in 1860, had two or three medical journals, not of extended circulation, while an Ishmaelitish scribbler or two issued monthly bulletins in a style of medical journalism now happily extinct. There were two medical bookstores, called publishing houses rather by courtesy than as a matter of fact, for scarcely a New Yorker but Bedford and Dalton and Draper had written a medical book, and very few had even edited or translated one. New York scarcely claimed equal rank with Philadelphia as a medical centre.—*Dr. B. D. St. John Roosa.*

Original Articles.

ON THE OCCURRENCE OF GANGRENE OF THE SCROTUM AFTER THE REMOVAL OF THE ENLARGED INGUINAL GLANDS.

BY RANDOLPH WINSLOW, M. A., M. D.

Demonstrator of Anatomy, University Maryland, Prof. of Surgery Womans' Medical College of Baltimore.

AND

WM. J. JONES, M. D.

Resident Physician at Bay View Hospital.

Several cases of gangrene of the scrotum following ablation of diseased inguinal glands have come under the notice of the writers, and, as the experience is novel to us, we lay the records before the profession, in hopes that similar cases may be reported, if they have been observed by others. Whether the occurrence of gangrene in these cases is merely an accidental complication due to septic or other extraneous causes, or whether it is a condition more or less adherent to the extirpation of the inguinal glands, is a matter about which we are entirely in the dark. In several cases of extirpation of inguinal glands under our observations, no bad symptoms whatever have occurred, healing going on promptly and satisfactorily; and as the operation is one of very great value in appropriate cases, it is important to ascertain whether there is an especial liability to the accident described. The scrotum is chiefly supplied by the superficial and deep external pudic arteries, with their corresponding veins; and its lymphatics are in direct communication with those of the groin. In the operation of extirpation of the inguinal and saphenous lymphatics these vascular and lymph vessels are liable to be interfered with, but one would scarcely anticipate any serious consequence from such interference, as there is an additional blood supply from the superficial perineal branch of the internal pudic. The cords and testicles were not involved in the gangrene in any case.

CASE I.—Universvity Hospital, 1881. Service of Dr. R. Winslow:

CHRONIC SCROFULOUS OR TUBERCULOUS ENLARGEMENT OF THE INGUINAL AND FEMORAL GLANDS, EXCISION, GANGRENE OF SCROTUM, DEATH FROM PYÆMIA.

J. T. A Frenchman, about forty years of age, was admitted into the University Hospital, on July 12, 1881. He was a cook by trade, but had not been able to pursue his calling for sometime on account of a chronic enlargement of the lymphatics of the groin and thigh, which suppurated and refused to heal. There was much inflammatory action in the cellular tissue around the glands. The man was run down and cachectic in appearance. On July 16th, the whole mass on both sides was removed, the dissection extending far down into Scarpa's triangle on the left side. Some hemorrhage occurred from the venous trunks terminating in the internal saphenous vein, and several ligatures were necessary. No special note was taken of the arteries. The dissection exposed Poupart's ligament and the fascia lata, and the femoral artery was seen pulsating under the fascia; carbolized oakum was used as a dressing. July 17th. Night sweats are complained of, for which arom. sulphuric acid gtt. xv. t. i. d. was given. July 18th. Temperature 102⅔, pulse 96, respiration 25. July 19th. Temperature 100°, pulse 89, respiration 18.

The wound looks healthy and granulations are appearing, but the physical condition of the man is bad. July 20th. Temperature 98°, pulse 96, respiration 20. Four days after the operation, he was able to walk around the ward. Two days later the wound began to lose its healthy appearance. In a few days the scrotum became œdematous, and by July 30th, gangrene had set in, which extended until one third of the scrotum became involved. His temperature however remained low, about 100°. Under the influence of 3 ss doses of tinct. ferri chlor. every two hours, forced alimen-

*Read before the Clinical Society, November 6, 1885.

tation and moderate stimulation, the gangrene was arrested, and repair began in both the scrotum and the wound. The vital powers, however, did not seem equal to the task of reparation, the wounds became pale, and discharged a serous fluid. He had rigors and sweats, and died in three weeks after the operation. The cause of death was probably pyæmia, though the autopsy did not reveal metastatic abscesses. One small abscess, discharging a bloody pus, was opened during life almost over the external iliac artery.

CASE II.—Was treated at Bay View Hospital. Service of Prof. Tiffany:

CHRONIC ENLARGEMENT OF INGUINAL GLANDS, EXCISION, GANGRENE OF SCROTUM RECOVERY.—REPORTED BY W. J. JONES, M. D.

C. B. Frenchman, æt. 40 years, occupation machinist. Was admitted into Bay View Hospital, on the 24th of May, 1884. He was found to be suffering from a chronic enlargement of the inguinal glands. In several places the glands had broken down and were discharging a sero-purulent matter. Poultices of flaxseed meal were applied and continued for sometime, but exerted no influence toward improvement. These were discontinued and iodoform and oakum were used instead. A tonic consisting of sulph. quin., grs. ii; tinct. ferri chlor., gtts. xx; was prescribed thrice daily. The condition of the patient remained unchanged and excision of the glands was decided upon. Accordingly about June 20th, the patient was etherized and the operation of excision of the glands was performed by Prof. Tiffany. Patient recovered well from the anæsthetic; the wound was dressed with iodoform and oakum. He was put to bed and got along well until about the fourth day after the operation, when the wound was noticed to be inflamed; this inflammation, erysipelatous in nature, rapidly grew worse, involving the whole of the scrotum. The scrotum became enormously swollen and œdematous, and in a few days sloughing of the tissue began. All efforts at treatment were fruitless, and the sloughing continued until the covering of the testicles and cords became exposed to view, finally the inflammatory condition ceased, and about July 1st, the wounds in the groin and the scotum took on a healthy appearance. Patient was treated all through the attack with tonics and good food, and on August 8th, 1884, he left the hospital, having made a good recovery. The wounds in the groins healed entirely, and the scrotum contracted considerably from the large amount of cicatricial tissue that was formed.

CASE III.—This case was admitted into Bay View Hospital, on March 5, 1885. Service of Dr. Branham.*

INGUINAL ADENITIS, EXCISION, GANGRENE OF SCROTUM, RECOVERY.—REPORTED BY W. J. JONES, M. D.

C. W., Irish, æt 30 years, occupation laborer. About the middle of February last he noticed a swelling beginning in the left groin, which gradually became worse, and about the middle of March the glands were freely excised by Dr. Branham. He was then kept quiet in bed and flaxseed poultices applied. Patient did well for about ten days, when it was noticed that the wound was taking on an erysipelatous inflammation. This condition rapidly spread until the whole of the scrotum and the upper part of the left thigh became involved. The scrotum was supported and elevated by means of a strip of adhesive plaster running across the thighs, and tinct. ferri. chlor. was given, gtts. xx doses every two hours. Under its influence the inflammation of the thigh began to subside except in Scarpa's triangle where an abscess was formed. This abscess was opened on April 13th, and about half a pint of pus let out. About this same time the scrotal tissue began to slough and in a few days, at least two-thirds of the whole scrotum had become gangrenous. Poultices of flaxseed were used and as fast as the slough took place it was removed. Good

*The after treatment of this case was conducted by Dr. W. B. Platt.

food and tonics were given. The patient soon began to improve and on May 1st was discharged from the hospital recovered. The necrotic tissue was replaced by a firm cicatrix, and, with the exception of the scar, no serious damage was done by the imflammation.

NOTES ON THE NEW ANTISEPTICS, HYDRONAPHTHOL AND THE POTASSIO-MERCURIC IODIDE.*

BY R. J. LEVIS, M. D.,

One of the Attending Surgeons to the Pennsylvania Hospital.

The following are the claims made for the newly-discovered antiseptic, hydronaphthol:

It is at least twelve times as effective as carbolic acid, and is entitled as a true antiseptic to occupy a position in the comparative tables next to the mercuric bichloride.

It is thirty times as potent as salicylic acid, sixty times as effectual as boric acid, and has six hundred times the antiseptic power of alcohol.

Hydronaphthol is soluble when placed in cold water to the extent of one part in two thousand. It is soluble in hot water in the proportion of one to one hundred; but when the water becomes cooled to ordinary temperatures a precipitate occurs, leaving a solution of one to one thousand. In this strength of one to one thousand it permanently prevents the development of the germs of putrefaction in all putrescible fluids.

Whilst the true antiseptic or *inhibitory* action of hydronaphthol in such cold aqueous saturated solution is perfect, its germicidal and proper disinfectant power is ineffective. For the destruction of already existing germs, such as have a tenacious vitality, as those of anthrax bacilli and pathogenic micrococci, it therefore cannot be relied on. As to its action in this regard, as compared with carbolic acid, it should be remembered that a ten-per-centum carbolic solution is required,—a strength practically improper in wound-treatment. In ordinary antiseptic practice, carbolic acid is valuable only on account of its inhibitory action.

The first use of hydronaphthol as an antiseptic was by Dr. G. R. Fowler, of Brooklyn, to whom the profession is indebted for its introduction to practical surgery. My own experience with the antiseptic action of hydronaphthol in the wards of the Pennsylvania Hospital and in private surgical practice confirms his observations, as given in his recent articles in the *New York Medical Journal.*

Hydronaphthol is a grayish substance, in the form of crystalline lamina, having a slightly aromatic taste and odor. It is soluble freely in alcohol, ether, chloroform, glycerin, benzole, and the fixed oils.

In the aqueous saturated solution of one to a thousand it is absolutely unirritating, and has no toxic action, either local or systemic; is free from unpleasant ordor, and has no injurious action on metallic instruments or on clothing fabrics.

Besides its use in aqueous solution, I have used it in the form of a powder diluted, preferably with the oxide of zinc in the proportion of one to fifty.

I believe that hydronaphthol may well displace carbolic acid from practical surgery.

The potassio-mercuric iodide is four or five times as powerful as a true germicide or disinfectant as the mercuric bichloride. For such use it is effective in aqueous solutions in the proportions of only one to twelve thousand.

The potassio-mercuric iodide is made by simply dissolving equal quantities of the biniodide of mercury and the iodide of potassium in distilled water. The solution is evaporated, and there remain yellow, needle-like crystals of the potassio-mercuric iodide.

In the use of such dilutions of this powerful antiseptic, local irritation is entirely avoided, and the risk of producing the constitutional effects of mercury is greatly diminished.

The introduction into surgical treat-

*Read before the Philadelphia Academy of Surgery, November 2, 1885.

ment of these two remarkable and powerful substances, hydronaphthol and the potassio-mercuric iodide, will do much to overcome some of the objections and inconveniences of antiseptic practice.

A CASE OF CHOLECYSTOTOMY.*

BY W. W. KEEN, M. D.†

Albert Henry K., German, age 45, residing in Philadelphia was admitted into the hospital September 21, 1885, during the service of Dr. W. W. Keen. Parents healthy. He is the only living one of twelve children; the rest died during infancy.

General health was good, with occasional attacks of gastro-intestinal catarrh. Four years ago he had a severe attack of colic, the pain arising in the right hypochondriac region and extending to the umbilicus. The attack lasted several hours, and was relieved by medicine. The following year he had a similar seizure, followed by a chill, loss of appetite, vomiting, and constipation, and in a short time the conjunctiva was jaundiced.

He had another attack June 12, 1884, followed by nausea, vomiting, chill, loss of appetite, constipation, high-colored urine and clay-colored stools, with marked jaundice of his whole body, which continued ever since. Since that time the attacks have become more frequent, occurring once or even twice weekly.

He had been, since January 1, 1885, under medical care, but with no improvement. He first came to the dispensary August 6, and was under observation and treatment, but without any change for the better.

Upon admission, it was noted that he had lost some flesh; his mind was dull; the skin, conjunctiva, and mucous membrane were intensely jaundiced; marks of scratching appeared on the abdomen, and he suffered much from itching and stinging at night; the pulse was 54 and full; tongue slightly coated with yellow fur in the morning. His appetite was poor, bowels costive, and the stools were of a clay color. He also complained of flatulence and constant tenderness and distress in the epigastrium. The urine was high-colored, acid, sp. gr. 1025; no albumen was detected, and no sugar; bile-pigment was present.

Physical examination showed a tumor below the margin of the ribs in the right hypochondriac region; it extended from the right nipple-line three and a half inches to the median line, and to within two and a quarter inches of the umbilicus. It was not absolutely flat upon percussion, but tender and elastic. The liver-dulness extended from the sixth interspace in the nipple-line to one-fourth inch below margin of ribs. The abdomen was not distended; spleen of normal size; lungs and heart both normal.

September 24. Had severe headache; pain in the epigastrium, followed by a rigor lasting three hours, then fever. 5 P. M. Temp. 101.5°; pulse 80; podophyllin (gr. ½ at night) acted freely on the bowels.

September 28. Dr. Keen introduced into the tumor a hypodermic needle, and thought that he detected a stone. A very small quantity of liquid was withdrawn; it was dark-colored, and mostly blood.

October 1. An aspirator needle was introduced into the tumor three inches, and a probe passed through it. A stone was detected.

October 4. He had a chill, which lasted three hours, followed by the usual symptoms. The operation which was appointed for the next day was, therefore, postponed.

October 10. Dr. Keen, assisted by Drs. Grove, Mears, O'Hara, Willitts, Elmer, Learned, Boyd, and others, operated, with the usual antiseptic precautions, including the spray, carbolic acid being used.

The surface of body was first washed off with carbolized water, and etherization was commenced at 1.30 P. M. An incision of three inches was made parallel with the margin of the ribs, com-

*Read before the Philadelphia Academy of Surgery, November 2, 1885.

†For the careful notes of this case I am indebted to Dr. Elmer, Surgical Resident of St. Mary's Hospital.

mencing one and a half inches below the ensiform cartilage, and extending over the prominence of the tumor. All the vessels were tied with catgut ligature. The abdominal walls were thick. All hemorrhage had ceased before the peritoneum was opened. Now the liver came into view, and what was thought to be the tumor—the distended gall bladder—proved to be an enlarged left lobe of the liver, presenting much more to the right than usual. The gall-bladder could neither be seen nor felt.

In order to obtain more room, the incision was prolonged about two inches to the right. The colon and omentum were now exposed. Still the gall-bladder could not be detected with certainty; but a hard mass could be obscurely felt, which was believed to be gall-stones. It lay transversely, directly in front and slightly to the right of the spine, and almost absolutely in contact with it. To obtain still more room to work at such a depth, another incision was made, beginning at the upper end of the first incision, and extending downwards in the linea alba three inches. The closest search was made for the gall-bladder, being still in doubt as to its situation.

From the posterior part of the transverse fissure, almost in contact with the spine, an apparently uniform mass, continuous with the gastro-hepatic omentum, extended downwards and forwards, in the posterior part of which, as stated, the gall-stones could be somewhat obscurely felt near the liver; and, farther away from it, a softer mass, which ought to be the flaccid gall-bladder. These lay in such relation to each other that the gall-stones were thought to be in the cystic and the common duct.

Into this softer mass—the supposed gall-bladder—a small opening was made; but it was soon evident that this was the duodenum, as the finger detected the pylorus. Discovering this, the wound in the duodenum was closed with five interrupted and five carbolized-silk Lembert's sutures. The harder mass containing the gall-stones was now carefully lifted to a slight extent by the finger and thumb, and the wall and tissues in front of it cautiously incised for about three-fourths of an inch, and two stones, respectively three-fourths and one and one-fourth inches in size, removed. The gall-bladder was as firmly contracted around them as a kid-glove clasps the finger, and contained absolutely no fluid. The opening of the cystic duct could be felt by the finger, and was patulous. No other stones could be felt. A probe, it was thought, could be passed from the cystic to the common duct.

The wound in the gall-bladder was stitched with four interrupted and four Lembert's carbolized silk sutures. All hemorrhage had apparently ceased. The cavity was carefully cleansed, and the abdominial walls, including the peritoneum, were sutured with wire, and the wound dressed with bichloride-of-mercury gauze. The operation lasted until 4.45 P. M. His pulse during the operation was never more than 75, nor under 60, and his skin was fairly warm; but his respiration, from early in the operation, was sighing.

After the operation, he suffered from moderate shock. Hot bottles were applied along his extremities.

5 P. M. Temperature, 99.5°; pulse, 88. He suffered very much pain and complained of thirst. Morphine, gr. $\frac{1}{8}$, and cracked ice.

5.30 P. M. Hiccough; relieved by atropia, gr. $\frac{1}{120}$.

7 P. M. Pulse 96, and compressible; temp., 99$\frac{4}{5}$°. Morphine, gr. $\frac{1}{8}$. Small quantities of brandy and water were given at intervals.

9 P. M. Feeling quieter. Still complains of pain.

11 P. M. Pulse 104. respiration 24; morphine gr. $\frac{1}{8}$, was given at intervals; through the night he gradually failed.

October 11. At 7 A. M., pulse very feeble and rapid; temp. 101$\frac{2}{5}$°. Digitalis and brandy were given; but he did not rally, and died at 8 A. M.

The post-mortem examination was made at 12 M. Rigor mortis well marked, though the trunk was still warm. All the abdominal contents were deeply jaundiced. About six to eight ounces of blood were found in the belly, and, as the greater part of it was behind the peritoneum and extended to and around

the right kidney, it presumbly came from vessels injured in the lifting of the mass in which the gall-stones were situated. This had been carefully done by Dr. Grove, as it was impossible to obtain access to it otherwise at such depth, but required some force. No hemorrhage had been observed at or immediately after the operation. There had been no bleeding from the operation-wounds, either in the shrunken gall-bladder, the walls of which were very thin, or from those in the duodenum or the abdominal walls. There was no hemorrhagic tendency noticed, as is so often the case in such operations. There also had been no escape of bile or intestinal contents into the peritoneal cavity. No organs were observed except those concerned in the operation.

The liver, gall-bladder, stomach, duodenum, pancreas, and colon were removed in mass, and showed the following facts:

The left lobe over the liver, especially its anterior portion, was much enlarged and somewhat twisted to the right so that its semi-lunar projection occupied the position of the gall-blander, and was easily mistaken for it before the operation. The liver was deeply fissured between the right as well as the left lobe and the lobus quadratus. No gall-bladder existed in the proper site for it, but it was found lying transversely in a shrunken condition, as stated far posteriorly. The common and cystic ducts were patulous. The wounds in the gall-bladder and the duodenum were effectively closed by the sutures, and no escape of the contents had taken place. No other gall-stones were found. The mucous membrane of the duodenum was deeply congested for a wide extent, undoubtedly from inflammation existing before the operation. The duct of the pancreas was pervious.

So far as I am aware, such complications as this displacement of the gall-bladder, its shrunken condition, and the impossibility of deciding what was and what was not gall-bladder have not before been reported. It may be said that the incision should have been first made at the place where the stones were felt; but it was decided not to do so on account of the obscurity with which they could be felt lying under considerable tissue, which might in the displaced position of the gall-bladder, be a part of the intestines or contain large vessels, and at the depth at which they were situated it would have been exceedingly difficult, if not impossible, to control the hemorrhage or repair the damage to the intestinal wall should it have proved to be the intestine. Indeed, I debated seriously even abandoning the attempt to remove the stones at one time, on account of the difficulty of reaching them; and, on reviewing the case, I am inclined to believe that it would have been better to close up the abdominal wound, and trust to the possibility of the stones ulcerating into the duodenum, to which the gall-bladder was already closely matted.

The fatal issue in the man's debilitated condition was due to the shock of a prolonged operation and the moderate after-hemorrhage.

One other point demands notice. It is very evident that the hypodermic needle-point did not touch the stones, and it is somewhat doubtful to me whether the probe passed through the aspirator-needle did, judging from the depth at which they were found. But the sensation of scratching such a stone was so deceptive that all three of the resident-physicians, as well as myself, were under the impression that the probe certainly did do so, and we were fairly certain that the hypodemic needle also did.

A Palliative of the Pains of Dyspepsia.—The *Union Médicale* attributes the following prescription to M. G. Sée:

Tincture of hyoscyamus } each	150 grs.
Tincture of conium }	
Tincture of gentian . .	75 grs.
Essence of anise . .	10 drops.

From ten to thirty drops are to be taken with each meal, as a remedy for the pains of dyspepsia and cancer of the stomach.—*N. Y. Med. Jour.*

Society Reports.

PHILADELPHIA ACADEMY OF SURGERY.

STATED MEETING HELD NOVEMBER 2, 1885.

D. Hayes Agnew, M. D., President, in the Chair.

Dr. R. J. Levis read a communication entitled

NOTES ON NEW ANTISEPTICS, HYDRONAPHTHOL AND POTASSIO-MERCURIC IODIDE.*

DISCUSSION.

Dr. S. W. Gross: Dr. Levis has made the statement that the potassic mercuric chloride is a far safer germicide than the ordinary mercuric chloride. The solution of one to twelve thousand is really not so much weaker, if we look at it properly. The potassic mercuric chloride is dependent for its activity on the biniodide of mercury. It is a well established fact that the biniodide of mercury is a far more powerful germicide than is the bichloride. Because we use a weaker solution is no evidence that it is not as strong as the bichloride. I can see no advantage in making the potassic mercuric chloride solution, unless it is to fix the biniodide. In preparing the solution of corrosive sublimate in which we wish to keep gauze, sponges, etc., for a long time, we added to it seven and one-half grains of chemically pure chloride of sodium, with the view of fixing the bichloride so that it will not be converted into calomel. The addition of an equal part of iodide of potassium to the binoidide will fix that salt so that it will not be decomposed. There is therefore really no advantage in it, except to prevent changes in the biniodide.

Hence this is not a new remedy, for the biniodide has been used as a germicide. I do not see any advantage of using a stronger substance in what is apparently a weaker solution. It is of course impossible to say anything as regards the constitutional effects, for Dr. Levis has not had sufficient experience to determine whether or not toxic symptoms are produced by this agent. There is no reason why,—if the potassic mercuric chloride is used as carelessly as the corrosive sublimate often is,—there should not be toxic symptoms produced. If the cases of poisoning with the bichloride of mercury, which have been reported, are examined, it will be found that the bichloride has been used in unusually large quantities. For example, a one to one thousand or one to two thousand solution has constantly been used as a fluid to irrigate the wound during a surgical operation. Again, in psoas and iliac abscess, where a large quantity of the solution has been introduced after the evacuation of the pus, toxic symptoms have arisen. If a little care is exercised, there is no reason why toxic symptoms should arise from any of the mercuric solutions.

In regard to hydronaphthol, I know nothing of it from experience. I, however, know that Dr. Fowler has been making experiments with it for years, and, even after the adoption of the mercural solutions, used saturated compress with naphthaline outside of the corrosive-sublimate dressings to keep the wound enveloped in the vapor of naphthol, according to his statement.

Dr. R. J. Levis: Dr. Gross will bear in mind that with the potassic mercuric chloride there is only one-fifth the amount of mercury used. We know that the mercuric bichloride is an unstable salt in the way in which it is generally used, and for ordinary uses it can hardly be made a stable salt.

Dr. S. W. Gross: It is a stable salt. A solution of corrosive sublimate in water can be kept for a week without any change. To make a stable solution for sponges and dressings, it is better to add chloride of sodium.

Dr. R. J. Levis: I used the term unstable with reference to the mercuric chloride in contact with organic matters. Under such circumstances it is liable to be converted into ordinary calomel.

Dr. S. W. Gross: This is a mistake. Corrosive sublimate does not become unstable in the presence of organic compounds. This has been asserted, but

*See page 59.

there is no proof of it. If it did undergo this change, why do we have toxic symptoms arising when large quantities of the solution are injected into abscess-cavities?

Dr. J. M. Barton: As regards stability, the mercuric chloride does not seem to undergo any chemical change. At the same time, it undergoes some change when brought in contact with organic matter. If this were not so, a large mass of odorous material could be disinfected with half a grain of corrosive sublimate.

Dr. Charles W. Dulles: It is well known that the salts of mercury in the presence of albumen are apt to be converted into albuminoids, but this does not prevent the constitutional effect of mercury. I believe that this change is not in sufficient quantity to interfere with the antiseptic properties of the substance. The effect of the potassic mercuric chloride in the presence of albumen is somewhat similar. Dr. Oliver who has made some extensive experiments in regard to albumen in the urine, has found that this potassic mercuric chloride is the most delicate test for albumen.

Dr. S. W. Gross: In corroboration of what Dr. Dulles has said, I would recall the fact that when Lister began the use of corrosive sublimate he employed a solution which was too strong, and found that a certain amount of erythema and vesication was produced. He now procures the serum of the blood of a horse and makes his solution in that way.

Dr. Addinell Hewson: I have had some experience with hydronaphthol, but I have seen it produce irritation, and even such erythema as was alarming. This was a solution of one to two thousand. The effects were produced within twenty-four hours. The patient experienced constant distress from the time of its application.

Dr. R. J. Levis: I have found the one to two thousand solution almost tasteless. I have placed it in one eye being conscious of its presence.

Dr. Addinell Hewson: In this case there was a tendency to erythema, and the result undoubtedly proved that the remedy had no effect as a germicide.

Dr. Levis: That is not claimed for it.

PIN FOR TREATMENT OF FRACTURE OF THE PATELLA.

Dr. Morton: I wish to exhibit a pin which I have used in the treatment of fractured patella. For a number of years I have been using the ordinary Malgaine's hooks and the modified Malgaine's hooks. It occurred to me that if I could pass a steel pin and keep the fragments approximated I should have an easier method than with the hooks. I devised this pin, which has a detachable handle and works as an ordinary Brainard's drill. In the case in which I applied it the pin went through without difficulty. Over the extremities shoulders were applied. The fragments were then not disturbed for three weeks. There was not the slightest irritation. Lead-water and laudanum were kept applied. When the pin was removed, I found under one of the shoulders a small collection of pus. In order to obviate this I have had a shoulder made which does not come in contact with the skin at a right angle. To avoid the possibility of pulling any pus into the bone when removing the pin I have made it in two pieces united in the middle with a screw. When it is desired to remove the pin, the parts are unscrewed and the two pieces removed. I have had less trouble with this than with any other method of treating fractured patella.

In introducing the pin I did not employ any anæsthetic, and the patient made no complaint. The whole manipulation did not occupy over fifteen seconds. It is impossible to apply Malgaine's hooks without an anæsthetic. I was surprised at the ease with which the pin passed through the bone. It met with no more resistance than it would in going through a hard Boston cracker.

I was unable to apply the pin until thirteen days after the fracture, on account of the effusion within the joint. I have never put on the hooks until all local irritation has subsided.

In this case I do not think that there is bony union. I have never seen bony union where there has necessarily been delay, but there is here exceedingly close union.

Dr. Wm. W. Keen reported a case of

OBSTRUCTIVE JAUNDICE, CHOLECYSTOTOMY FOR IMPACTED GALL-STONES.*

DISCUSSION.

Dr. Wm. Hunt: What has been the success following this operation?

Dr. Keen: I have not had time to gather the cases together; but when I prepared my paper last year there were thirty-eight cases, with eight deaths.

Dr. S. W. Gross: The percentage of deaths after cholecystotomy is eighteen. The percentage of deaths is far greater than after removal of the gall-bladder, or cholecystectomy.

Dr. J. Ewing Mears: This case serves to confirm what every one who has had anything to do with abdominal surgery believes: that it is frequently impossible to tell what will be found in the abdomen before it is opened. This case was carefully examined before operation, and what was supposed to be the gall-bladder was outlined; but when the abdomen was opened, this proved to be the left lobe of the liver. This may be regarded as one of the most obscure cases of cholecystotomy that has yet been performed. In the reported cases there has been no difficulty in locating the position of the gall-bladder.

Dr. W. W. Keen: In the three prior operations which I had done, there was no difficulty in finding the gall-bladder.

DEFORMITY OF THE UPPER EXTREMITIES.

Dr. W. W. Keen: I have here a patient with a deformity of the upper extremities, which I supposed is due to rickets. Precisely similar conditions I have never before seen. This girl is in her fifteenth year, a mulatto, tall and rather slender for her years. One year ago she began menstruating, and at the same time noticed the commencement of the changes which are now most distinct in the right wrist. There is also marked angular deformity at the elbow. Feeling the olecranon process, there is found considerable relaxation of the ligaments, allowing the ulna to be moved in different directions. In the wrist there is apparently no mechanism which would account for the deformity present. The deformity of the left wrist can, with the exertion of considerable force, be reduced. I would call attention to the ease with which the deformity of the elbow would be overlooked. When the hands are pronated it is not seen; but it is only observed in supination. The other bones of the body are free from evidences of richitis. There is no trouble about the head, no beading of the ribs or enlargement at the ankles. There is no evidence of inherited specific disease; the father died of consumption, the mother is living and perfectly healthy. There is no evidence of specific disease in the condition of the teeth.

Dr. Charles W. Dulles: Would this not be more properly called a case of osteo-malacia? Rickets is an affection of the bones in the progress of their growth. Osteo-malacia is the term applied to the condition in which bones, having attained their proper development, undergo softening.

Dr. Keen: The bones are not curved to any extent, and in no other bones is there a tendency to softening.

Dr. R. J. Levis: My opinion is that the case is really a neurosis. I look on it as a paralytic condition rather than a true bone-affection. It is analogous to some forms of club-foot, and particularly to knock-knees and the like, which, we know, occur from irregular muscular action.

Dr. W. W. Keen: I cannot understand how this condition could be due to muscular action, either paralysis or contracture. There is no evidence of such a condition. No muscle is tight, and no muscle springs into relief at any point. The muscles seem to act properly, and the trouble appears to be in the bony system. In consequence of the change in obliquity, the muscles which go across as chords of the arc tend to increase the deformity.

My attention has been drawn to the diminished size of the head of the radius. This might have something to do

*See page 60.

with the deformity at the elbow, but it could have nothing to do with the condition of the wrist..

Dr. Wm. Pancoast: I noticed that, on pressing the radius firmly against the ulna, a grating could be produced. This was only elicited on firm pressure.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD NOV. 5, 1885.

The President, B. F. Baer, M. D., in the Chair.

Dr. John M. Keating presented a paper entitled:

LYMPHATIC LEUKÆMIA IN CHILDHOOD.

The short paper, which by invitation I propose to read to you this evening, will I am sure prove of interest on account of its clinical rarity and the infrequency with which we meet the disease in current literature. To make the subject more interesting and more lucid, at the risk of recalling to your memory matters already familiar, I will premise with a few remarks on the blood in health in children, and briefly with its diseases.

There is a uniformity of composition of healthy blood which is curious. This is brought about by that equilibrium which is so striking in textures regulated by the production and waste.

The blood corpuscles which we are called upon to study are: 1st, the *red* of which there are floating in the plasma, about 5,000,000 to the cubic millimeter. These are about 1-3200 of an inch in diameter. 2d, the *white* of a diameter of 1-2500 of an inch, having the proportion of 1 to every 300 or 500 red. 3d, the nucleated red found in the fœtus and infant and disappearing about the third or fourth year of life. These may contain one or more nuclei in some instances protruding from the cell. They measure from 1-1400 to 1-2000 of an inch. 4th, the *hemuto-blasts of Hogem*—"small discoid, colorless, corpusclar, normal constituents of healthy blood—in drawn blood they aggregate in clumps known as Schultze's granule masses." As to the origin of the red corpuscles I will quote: "they are developed from colorless corpuscles, the lymph cells or leucocytes. The nucleated corpuscles of the embryo also aid in the development. These nucleated cells disappear early in childhood and are then found only in the red marrow." It is Osler's opinion that "they apparently originate from colorless marrow cells which gradually become more homogenous and hemoglobin develops in the protoplasm, the nucleus degenerates and disappears, when the cell has the appearance of an ordinary red disc." Possibly these nucleated cells may give birth to red cells by the process of budding. The relations of the cystogenetic organs to blood formation has always been somewhat debatable ground; the present state of our knowledge may be formulated about as follows: "The spleen certainly takes part in the development of colorless corpuscles, but its participation in red blood formation is more doubtful; though the opinion prevails widely that the spleen is one of the important organs in the formation of red corpuscles, the evidence for this belief is of an exceedingly scanty nature.

The lymphatic glands and adenoid tissues in other regions are the seat of constant production of colorless corpuscles, but of their relation to the red corpuscles there is the same lack of information as in the spleen."

Neumann and Bizzorzero pointed out the fact that the red marrow appears to be the seat of blood formation. In the adult it is the only region in which embryonic or nucleated red cells are found. In the young the marrow fills the long bones.

It is Osler's opinion, and I have quoted from his recent admirable articles on this subject, that the evidences of the development of red corpuscles in the marrow rests upon the constant presence of nucleated cells infiltrated with hemaglobin and of their fission. In excessive hemorrhage natural or indirect, it appears to undergo active proliferation, and it is an interesting fact to notice the marvelous rapidity with which the red corpuscles are reproduced after hemorrhage. The

amount of hemoglobin in healthy blood, according to Preyer, is 13.45 grammes to 100. This relation is important for us to bare in mind as it proves an index to treatment. The color test being used I feel certain that before long it will be a matter of more than ordinary interest to the general practitioner when the means of applying the color test shall be generally accepted as has been done already to daily practice.

In the new-born the blood is said to amount to 1-10 part by weight of the body. In the adult 1-12 to 1-14. I may also note that it has been shown by Neumann that the liver in the embryo may be the seat of the formation of corpuscles, though in the adult it is the seat of their destruction.

Let us now take up the subject of anæmia in children. Were I to attempt to do justice to this condition it would take far more time than your patience would allow. We will omit that caused by hemorrhage, by toxic agents, by mineral poisons, by miasm, by syphilis, in which we have an increase in the watery elements and a diminution in the albuminous, and consider that dependant upon disorder of the blood-making organs themselves, and here we meet with a most difficult problem. By the blood-making organs we understand the spleen, the lymphatic tissues and the bone marrow, remembering, of course, that some of these tissues have also to do with blood destruction. We, however, definitely know that an increase in the cystogenetic tissues is associated with disturbances in blood formation. The organ undergoes a hyperplasia particularly of its fibrous constituent and the marrow of the bone changes from normal appearance to one like spleen pulp. The blood of all patients suffering from anæmia presents a reduction in the number of red corpuscles This is true, no matter whether the seat of the trouble is located in the spleen, the marrow of bone or in the general lymph glands, the white cells may or may not be increased, the clinical features of a case of anæmia will be strikingly alike let the cause be in any one of the blood-making organs all the more important symptoms will be present. To quote once more such common features would be "the progressive anæmia with its group of circulating symptoms, the irregular febrile reaction, essential fever of anæmia, the absence of marked emaciation, the tendency of effusions of serum, the progressive debility, the recurrence of hemorrhages, gastric and intestinal, gastric and intestinal disturbances, and the resistance to treatment."

These affections that have so many symptoms in common are grouped as distinct diseases under the following headings, viz.: leukæmia, Hodgkin's disease (anæmia lymphatica), splenic anæmia, and idiopathic anæmia.

Leukæmia signifies a hyperplasia of the blood-making organs with anæmia and an increase in the colorless corpuscles. Of this form we have three varieties, the splenic, lymphatic and medullary. Leukæmia is present at all ages; the youngest case recorded by Osler being an infant of eight months. The chief symptoms are insidious onset anæmic appearance, bleeding at the nose or other hemorrhages, frequent diarrhœa or other gastro-intestinal disturbance. The spleen is enlarged, gradually increasing in size from the onset and finally it may interfere with the circulation and cause difficulty of breathing by pressure. Late in the disease the liver is also enlarged. The lymph glands in most cases are affected and sometimes slightly enlarged. The tonsils and follicles of the pharynx are usually enlarged. The lymph glands of the intestines and of the peritoneum are always enlarged. Fever is present and increases as the case progresses and is usually of the remittent type. But the most important aid to differential diagnosis is the mocroscopical examination of the blood. This I give in detail in the case that forms the basis of this paper, which I will now relate. I was called in consultation by Dr. I. W. Gadd, of this city, to see the child with him the latter part of last month, and the following notes were given by Dr. Gadd.

Mamie McC., aged 4 years and five months; had measles when about two years old and from which she recoved

without complication or sequelæ. About August, 1884, the tissue surrounding the eye became much inflamed and swollen. The swelling increased so much that the eyelids could not be opened for several days. After continued poulticing an abscess formed and broke discharging a quantity of pus, and continued to do so for a considerable time, but finally healed up with small scar. The child never complained, yet was pale and did not want to play as other children did. I believe this was more due to her disposition than to the effect of any disease.

About midsummer there appeared a rash, all over her body, very thick and resembling the eruption of measles; as it matured it was crowned by small white caps or heads. The epiderm soon came off in large patches. The child had no fever. As the eruption faded the mother observed purplish spots, like bruises, making their appearance. These were considered, by the parents, to be bruises due to falls. No attention was paid to her condition until Sept. 28th, when I was called in the evening to arrest an epistaxis which had existed most of the day. I found the child lying on a sofa, though able to sit up, with blood slowly trickling from the nose, each nostril contained a large clot. The child appeared very anæmic, with slight fever, yet did not complain of anything except weakness. The mother stated that the appetite had been very poor for sometime past. The bleeding from the nose was very easily arrested by removing the clots and packing with a strip of lint in each nostril. I also gave the following internally:

℞. Acid gallic, gr. xxx,
Acid sulph. dil., ♏ x l,
Ext. ergot fl., ♏ xxx,
Syrup, ℥ j,
Aqua q. s. ad. ℥ ij.

M. et sig. A teaspoonful in water every hour. Also ordered her as much milk as she cared to take with the precaution that she should sip it slowly. Tuesday I saw her and found her in the same condition, except that the epistaxis had been arrested. I thought it best not to remove the lint packing. It now being daylight her mother called my attention to the bruise-like spots over her body. These were in size from that of a two-cent piece to that of a fifty-cent piece, and two of them, situated one over each trochanter, were as large as silver dollars, with the exception of these two they were all, I believe, situated over the soft parts, such as over the belly of a muscle and varying in color according to age from a bluish-black to a greenish-yellow. She still had some fever, and her heart was more rapid in its action than normal; hence I gave her in addition to the gallic acid and ergot mixture:

℞. Liq. potass. cit., ℥j,
Spts. æth. nit., ʒ ij,
Tr. aconite rad., gtt. xv,
Syr. limonis, ʒ iv,
Aqua q. s. ad., ℥ij.

M. et sig. Teaspoonful every two hours.

The following Wednesday morning I found her feeling somewhat better, though still having slight fever; pulse 124 per minute and moderately weak in character. I did not detect any abnormal heart sounds. I removed the lint packing without any further bleeding and with much relief to the patient. I then ordered tr. digitalis in three drop doses every three hours, and also the following:

℞. Quin. sulph., gr. xiij,
Tr. ferri citro-chlorid., ʒ j,
Syr. tolu, ℥j,
Aqua, ʒ vij.

M. et sig. Teaspoonful every three hours.

Thursday I found the patient, to use her own language, well; evidently much better. Fever had entirely disappeared; the heart's action remained abnormally rapid. The cervical glands were slightly enlarged, but no enlargement of the tonsils and apparently no inflammation of the fauces. The treatment was continued with the addition of more nourishing food, beef-tea, wine-whey, etc. The child seemed so much better that I said it might come to my office the next morning instead of my going there. Later in the same evening she took a sudden change for the worse, but I was not sent for until Friday morning. Now the patient was suffering from high fever, 104° F. in the axilla, pulse 134 per minute, compressible. The cervical glands

much enlarged and very hard; the bowels had not been moved for twenty-four hours; the tonsils were but very slightly swollen; there were no patches in the throat. Thinking that possibly she was developing a malignant form of diphtheria, I at once put her on the calomel treatment until the bowels were moved, giving her three grains, repeated in two hours, and then two grains when the bowels were moved freely, and the calomel was stopped. I also gave suppositories of two and a half grains of quinine every two hours. Also,

℞. Spts. ammon. acet., ℥j,
Spts. æth. nit., ʒij,
Syrup, ʒiv,
Aqua, ʒij. M.

Sig. Teaspoonful every two hours.

I continued the tr. digitalis in five drop doses every three hours. I also applied hot flaxseed poultices to the enlarged glands, and at noon plenty of beef tea and milk, but the child did not care for food and it was difficult to get her to take any nourishment. At mid-day I noticed for the first time, although I had carefully and frequently listened before, a systolic heart murmur. The temperature was but little affected during the night, and next morning (Saturday) at 7.30 A. M. I found it as high as ever, 104°, F. in the axilla. Fearing that endocarditis had set in from the continuance of high fever and the heart murmur. I at once applied a mustard plaster to the pericardium, followed by a poultice, giving internally potassium iodide and ammonium carbonate, continuing the digitalis until noon when I met Dr. J. M. Keating in consultation.

Physical signs showed, in addition to what has been mentioned, an enlargement of the spleen, yet there was no history of malaria. Dr. Keating did not think that endocarditis had set in believing the murmur to be rather of a hemic character, yet as a stimulant to the heart suggested the application of a blister; internally, very small doses of Basham's mixture every three hours, with the free use of alcohol; beef juice in small amount, &c.; the temperature to be kept down to 102°, or lower by means of the wet sheet. On examining a specimen of the urine which had just been passed, and the first that I had been able to obtain, I found it to be of sp. gr. 1016, of a light straw color, free from albumin and sugar. The child could not retain either the medicine or beef juice. The nose again commenced to bleed, to prevent which I again plugged the nostrils. Soon large clots of coagulated milk were vomited, the result of having been given by half-cup-fuls at a time which was entirely contrary to my direction. Her stomach soon became settled and she took brandy and crushed ice in small quantities. We wrapped her up in a wet sheet and then poured cold water over her until the temperature came down to 101° in the axilla, which required about 35 minutes; she was then wrapped in a blanket. In two hours the temperature was again 104°. We gave several of the wet packs during the afternoon and the evening, and not withstanding we were at the same time giving 2½ grains of quinine every hour by suppository, the same rise in temperature was observed after each. During the night she took her medicine regularly; alcohol, water and beef tea were also administered. Sunday morning (the day of her death) I found her to all appearance bloodless, pulse rapid and small, respiration shallow and too frequent, temperature rising to 104°, after the wet pack as before. During Saturday night she had removed the packing from the nostrils which allowed a slight oozing of blood, and this having been swallowed gave rise to vomiting of clotted blood; this continued, after the bleeding from the nose had been again checked, at intervals of ten to fifteen minutes which gave me the belief that there was a slight hemorrhage into the stomach, these clots differing somewhat in form and color from those which I ascribed to the epistaxis. The heart became more rapid, 138 per minute, and the patient gradually sank. She died at 6.30 P. M. in great agony, giving two or three shrieks which were quite loud considering her weakened condition.

Dr. Keating remarked that Dr. William Osler had kindly examined for him

a slide of blood and reported as follows: "Report on slide of blood sent by Dr. J. M. Keating. Examination about three hours after withdrawal. *Red corpuscles* present no special alteration in size or shape. *Colorless Corpuscles* greatly increased in number, 50 or 60 in each field of the No. 7 Hartnock. They present remarkable variations in size, many are small, not more than one-third the size of the larger forms; they resemble the smaller colorless cells which Virchow has noted to be present in cases of lymphatic leukæmia. Many of the cells have feeble amœboid movements. *Neucleated red corpuscles* not observed. *Schultz's granule mass*, (often abundant in leukemia) scanty."

The relation of the increase in number of the colorless corpuscles above noted to the increase in size of the glands and cystogenetic tissue is indeed hard to solve. The increase in size and hyperplasia of the spleen in leukæmia and anæmia are histologically identical. We must remember that the view that colorless corpuscles are changed into red corpuscles is not fully established, hence, also, that it is not proven that the excess of corpuscles is due to failure in the change to red ones. In such cases the prognosis when the disease is detected at its incipiency, may be favorable under rigid treatment of fresh air, suitable diet, iron, quinine, and arsenic and salt bathing; but in marked cases that have existed for some time with advanced symptoms, the result is fatal.

Dr. Goodell inquired if there was any distinguishing points between perpura hemorrhagica and lymphatic leukæmia. If there is a deficiciency of red blood corpuscles, why do red patches occur so easily?

Dr. Keating remarked that the subject under discussion was dependent upon certain conditions,which physiologists are still debating. In leukæmia we have as a diagnostic feature an involvement of the lymphatic system more or less, a hyperplasia of the tonsils, lymphatic glands of the peritoneum and of the intestines, also of the spleen and bone-marrow, all of them being more or less connected with red cell formation; but the principal diagnostic point is the increase in number of the colorless cells, as is noted in Dr. Osler's report just presented. The hemorrhages in these cases are possibly due to a diapedesis or capillary rupture. In what is known as perpura hemorrhagica there is an exudation of blood cells or the hematin from their destuction into the rete mucosum and the papillary layer of the cutis; of course capillary ruptures may occur with profuse hemorrhage. The blood cells (red) are usually diseased, they become crenated or they cease to form rouloux, and possibly the plasma may be at fault. The microscope alone will reveal the distinguishing features. Perpura may be considered a symptom accompaning a dyscrasia in which the blood itself is involved, not merely the organs of its production.

(*To be Continued.*)

Sulphurous Acid As a Disinfectant. —At a recent meeting of the Académie de Medicine (*Jour. de Med. et de Chir Fran.*), M. Dujardin-Beaumetz gave an account of some experiments made by him at the Cochin Hospital. He says that sulphurous acid is the best disinfectant, and that it destroys all the organisms contained in the rooms, with the exception of the bacillus anthracis. He has tried the bottles of compressed sulphuric acid recommended by M. Pictet, of Geneva, but their high price is a serious obstacle to their use. It is better to burn, in the closed room, about one ounce of sulphur for each cubic mètre of air. The sulphur is mixed with a little alcohol on a saucer placed on sand. Sulphurous acid spoils many colours, and all metals, but the latter can be protected by a thick layer of grease.—*Br. Med. Journal.*

A New Medical Journal in Buffalo. —We have received the first number of a new monthly journal entitled "The Medical Press of Western New York," published in Buffalo. It is edited by Dr. Roswell Park, of Buffalo, assisted by Dr. M. D. Mann, of Buffalo, Dr. Ely Van de Warker, of Syracuse, and Dr. W. J. Herriman, of Rochester.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, NOVEMBER 21, 1885.

Editorial.

THE BALY MEDAL AND A GENERAL PRACTITIONER.—Mr. William Kitchen Parker, a general practitioner of medicine, has recently received the Baly medal, presented by the Royal College of Physicians, for his researches in minute comparative anatomy, particularly the anatomy of the skull. This medal is awarded once in two years as an acknowledgment of original work or research. Sir William Jenner, the President of the College, in presenting this medal to one engaged in general practice, took occasion to compliment Mr. Parker on the fact that he had been able to carry on this character of scientific work in the midst of the absorbing duties of a busy practice. Sir. William Jenner was in a position to appreciate the significance of this effort from the fact that he had begun his own career as a general practitioner.

It may not go amiss to remind our readers, many of whom are the busiest of busy practitioners, that Mr. Parker does not stand alone in the enjoyment of this distinguished achievement. A creditable amount of the valuable original work which has been given to the scientific world has come from the labor of busy general practitioners who have descended from the toil of a routine life to the recreation of original investigation.

DEATH OF DR. W. B. CARPENTER.—In the death of Dr. Wm. B. Carpenter the profession in Great Britain, and, we add, throughout the entire world, is called upon to lament the loss of one of its most distinguished representatives, and one of its most able exponents of scientific culture and progress. As an eminent physiologist, physician and author Professor Carpenter was known to the entire medical and scientfiic world. His text-books on physiology have been thoroughly familiar to all modern students of this branch of scientific study and have, perhaps, passed through a larger number of editions than any works on a similar subject. Professor Carpenter was born at Bristol, England, in 1813, and was therefore in his 73d year. He had lived in an era of most astonishing progress in scientific development, and he has enjoyed the distinction of being one of the truly great men of his generation who were able to contribute largely to this growth of knowledge and scientific research.

His death occurred in London, on November 9th, from the effects of terrible burns caused by the upsetting of a lamp while he was taking a vapor-bath for rheumatism.

PASTEUR AND HYDROPHOBIA. — M. Pasteur claims to have recently added another triumph, to those formerly achieved, in the discovery of a specific virus which is a prophylaxis against hydrophobia. He asserts that he has fulfilled a promise held out some two years ago, to the effect that he would discover a cure for this disease, which has so long baffled all the efforts of science.

Some time ago M. Pasteur succeeded in rendering proof against rabies a number of dogs experimented upon, but to ascertain that immunity had really been given, he had to wait some four months after the inoculation had taken effect. In order to obtain a virus of different degress of strength, and more prompter and more certain in its results, a rabbit was inoculated with a fragment of tissue taken from the spine of a rabid dog. The incubation of the poison occupied

15 days. As soon as the rabbit was dead, a portion of its spinal marrow was in turn inoculated into a second rabbit. This process was continued until 60 rabbits had been inoculated. By continuing these successive cultivations in this manner he succeeded in obtaining a virus of increased virulence and shortened incubation period. He also ascertained that exposure to dried air diminishes the virus and reduces it force. He therefore keeps the spinal cords of these rabbits in perfectly dry tubes for varying periods until he obtains a virus altered to any desired degree. By inoculating his subject with this virus the period of incubation was found not to exceed one week, and the subject was found to be absolutely proof against the disease.

An opportunity for proving the protective value of this virus on the human subject was presented to M. Pasteur in July last. On the 6th day of that month a young Alsatian, named Joseph Meister, who had been severely bitten in no fewer than 14 places by an undoubtedly rabid dog, presented himself at M. Pasteur's laboratory. The case, left to itself, being considered hopeless by M. Pasteur, Professor Vulpian, and other high authorities, the patient was submitted to the same series of inoculation that had been so successful on dogs. As a proof, a series of rabbits were simultaneously subjected to the identical process. The youth was inoculated 60 hours after the bites of the rabid dog had been inflicted. The inoculations were repeated twice a day for a fortnight with virus of successively increasing strength. After an interval of one hundred days since he underwent the last inoculation he is in perfect health.

M. Pasteur has another patient under similar treatment whom he is confident of curing.

The result shown in this experiment upon Meister is certainly a most encouraging one, still it is too soon to assert in the face of one single experiment that the specific virus has been dicovered which will bring about a similar result in other cases. The distinguished French savant is entitled to the congratulations of the scientific world for the brilliancy of his researches in this direction, but we are persuaded that the results are entitled to the confirmation of a larger experience and longer time before they should be accepted as fully established. It is well-known that hydrophobia in the human subject may not make its appearance for months and even years after the bite of the rabid animal was inflicted. In a certain number of cases the disease never makes its appearance even where the question of inoculation is not disputed. It certainly will be a matter for great rejoicing if M. Pasteur's researches in hydrophobia should prove to be as successful as his inoculations in splenic fever and anthrax. We prefer, however, to withhold our acceptance of his results until confirmed by a longer period of time than one hundred days.

The Abuse of Medical Charities.—Several of our contemporaries have recently devoted their attention to the discusion of the subject which heads this article. It is quite evident from the views which have been expressed that the subject is one worthy of serious consideration by the profession. It appears that the abuses of medical charities are not confined to our country, but have been experienced by our brethren in Great Britain, where, as we all know, the interests of our profession are most thoroughly considered and most carefully organized. The *British Medical Journal*, in its issue of September 19th, has called attention to the growing abuse of medical charity in England, and has urged that steps be taken to diminish the present extent of this evil. Our able contemporary asserts that "no profession does so large homage to real charity; but none is the victim of charitable schemes to a like approachable extent. Many influences seem to impel medical men to be lavish of their professional wealth. . Ambition for a higher status, or even, now and then, other motives even less defensible, cause members of the profession to surrender the just rewards of their services. So it happens that any philanthropic individual, ambitious of vicarious charity may always reckon on the gratuitous co-opera-

tion of the medical man." It is admitted that an apology is to be found for much of the gratuitous aid dispensed by our charities. Nevertheless, it is asserted that a point is reached at which free hospital and dispensary relief becomes prejudicial to the community. The very pertinent questions are asked. "Have we not already reached that point? Are not medical men unwisely lavish of their services to the multitude, and unjust to themselves? Do they not by the reckless manner in which they employ their stock-in-trade—their acquired knowledge and skill—depreciate the value of that commodity and bring it into contempt?" To these questions our contemporary gives an affirmative answer. "Medical charity has become an abuse. It is a social malady, and, unfortunately we discern no adequate cure for it." The good done by medical charities is not denied, but the "evil is fast outrunning the good, the manliness and independence of society, in its middle and lower grades especially, are sapped by the lavish distribution of medical assistance." Such is the picture our British contemporary paints of the abuse of medical charities in England. This picture is not too highly colored. It portrays a state of things which we are beginning to witness in our own country. The growth of medical charities in the States has assumed very large proportions within recent years and already begins to make onerous demands upon the profession. It cannot be said that we have too many charitable institutions for those really deserving of charity, but we have too many inferior and carelessly managed hospitals and dispensaries which fail to discriminate between real and assumed charity. The only way to correct the evil of gratuitous practice to certain classes of people is to exercise gratuitous medical attendance with care and discrimination. This should be done not only in hospital and dispensary service, but, what is more important, among a large class of people who are attended at their homes—the majority of whom are perfectly able to pay for medical service—who impose upon their medical attendants by classing themselves with the deserving poor. In every community there are a number of people who demand and receive a large share of gratuitous medical service who could afford to pay a small consideration for professional attention. A few of these would very cheerfully pay something if it was exacted of them. Another way in which impositions upon the profession are encouraged, is in the careless way professional accounts are rendered and collected. Many people take advantage of the physicians' loose business methods and deliberately determine to dead-beat him out of his well-earned reward. The medical attendent prefers oftentimes to suffer a loss rather than be annoyed with the trouble of collecting an account. This fact is well known, and it is acted upon by the frauds who thrive in every community by their wits and dishonesty. It is clearly a duty which every physician owes to his brethren to discourage such practices. No physician, however large his emoluments from his professional work, should permit himself to be imposed upon by the crafty designs of this well-known class of people. The question of fées is a very distasteful one to those physicians who are deeply interested in the beneficent and absorbing study and practice of medicine, and many, who do not live by their professional work, are disposed to turn up their eyes in holy-horror when any reference is made to the subject. This modesty and delicacy of sentiment may be all right for a limited few, who enjoy peculiar professional advantages, but it will not meet the wants of the large majority, who work for hire, and whose sole support for themselves and families must come from their hard toil, in which they often sacrifice both health and life. It is for this class of practitioners that the utmost consideration should be shown by their more fortunate professional brethren. It is to these men that the abuse of medical charities means an increase of the toil and hardship of professional service, and it is in behalf of these men that efforts should be made to keep these abuses within narrow limits.

Miscellany.

On Local Asphyxia of the Extremities.—Cases of local asphyxia and symmetrical gangrene of the extremities have been recently described by Messrs. Verneuil and Petit, who are of opinion that paludal cachexy plays an important part in the etiology. It is interesting to compare their observations with that of M. Bouveret, which has been published in the *Lyons Medicale* for June 8th, 1884. The patient, a woman, aged 68, lives in a country where ague is endemic and she has been repeatedly attacked by it. She also suffers from atheroma of the arteries. In January 1883, she noticed that the middle finger of her right hand was cold and of a dark colour, but the normal temperature and colour returned after dipping her hands into warm water. Some time later, the other fingers of the right hand were similarly affected; and little by little the disease progressed, so that now all the fingers and toes, as well as the palm and back of both hands, become at times cold and livid. Purple patches also appear occasionally on the forearms. The sensitiveness of the skin in the affected parts is much diminished, and sometimes even quite abolished. Dipping the extremities into warm water causes a temporary disappearance of the symptoms.—*Br. Med. Jl.*

Capsicum in Hæmorrhoids.—A case is mentioned by a correspondent of a Peruvian medical journal of a case of bleeding piles cured by capsicum. The patient was a man of 28 years of age. He was much distressed by passing variable quantities of blood after going to stool, and suffered a good deal from anal irritation and tenesmus. No tumor could be detected. He had formerly been in the constant and daily habit of using a violent purgative for ten months, and after he left it off, obstinate constipation followed, and it was under these circumstances that the hæmorrhage commenced. The writer tried all kinds of remedies and regulated the diet without producing any great improvement, and at last was contemplating surgical measures when he happened to mention the case to a hospital physician, who suggested a trial of capsicum, as he had himself been cured of a very obstinate form of chronic dysentery by its means, and he felt sure that it possessed the property of acting on the rectum. This was consequently prescribed with meals, and the doses gradually increased. A marked improvement soon was observed, and at the end of a couple of months a complete cure was effected.—*London Medical Times.*

Hamamelis Virginica in the Treatment of Prostatic Disease, and of Buccal Cancer.—Dr. Duncan J. Mackenzie, of Glassop, England, writes as follows to the *British Medical Journal.* — Two cases that have recently come under my care seem to me interesting in connection with the use of hamamelis virginica.

One is a case of enlarged prostate requiring the use of the catheter, in which periodical hæmorrhages have occurred simultaneously from the urinary passages and the rectum, no doubt from a congested condition of the veins of both parts. In this case, washing out the bladder with a solution containing one drachm of tincture of hamamelis, and one half-drachm of carbolic acid, in about twenty-five ounces of warm water, has had an excellent effect in arresting the bleeding, and also in allaying the irritability of the parts. Since the use of the injection, the urine has been passed without the catheter; but that is probably due to relief of congestion by the bleeding. The other means found most useful have been leeches to the perineum, and saline purgatives.

The other case is one of cancer begining in a rare seat—the right tonsil, and subsequently involving the tongue. In the diagnosis of this case, I had the assistance of Dr. Hodgkinson, of Manchester. A short time ago, a smart hæmorrhage occurred, and tincture of hamamelis in ordinary medicinal doses was prescribed. The bleeding was arrested; but the medicine was found to have such an excellent effect in preventing the formation of sticky secretion on

the ulcerated surface, and in adding to the comfort of the patient, that is was adopted as a permanent mode of treatment.

The above are comparatively simple cases, and the effects of treatment can only be palliative; but it seems to me that an account of them, as a contribution to the knowledge of the therapeutics of a new drug, may be of some use.

Iodide of Potassium in Habitual Abortion.—M. Goshkevich says that, though it is usually believed that iodide of potassium tends to produce abortion, and its use is, therefore, generally avoided in pregnancy, he advises that it should be given in cases of habitual abortion. The causes of this are obscure, but the best known of them is undoubtedly syphilis. With this in view, he prescribes the iodide even when no syphilitic symptoms have been recognized, and gives two cases to prove the advantage of this. The heart-sounds and movements of the fœtus, both of which had become almost imperceptible, improved under five grains three times a day, and diminished whenever the medicine was stopped. In each case the normal period was completed, though previously both the patients had been accustomed to miscarry during the second half pregnancy.—*The Lancet.*

A Case of Rhinolith.—At a recent meeting of the Imperial and Royal Medical Society of Vienna, Dr. Ottokar Chiari showed a nasal concretion, which he had removed from a young lady. For more than ten years she had been unable to breathe through the nose, and had had an abundant purulent discharge. The mucous membrane of one nostril was much swollen, and a rough hard body could be felt with the sound. Dr. Chiari broke off portions of the substance with forceps, and then removed the rest. The whole consisted of phosphate and carbonate of lime, and contained in the centre a metal button, concerning the introduction of which into the nose the lady could give no information. The extraction of the rhinolith produced slight hæmorrhage, which was easily arrested.—*Brit. Med. Journ.*

Vicarious Menstruation.—Puech, in his collection of over two hundred cases of vicarious menstruation, gathered from different authors, sums up his statistics as follows: Menstruation at roots of hair, 6 cases; by auditory canal, 6; by lachrymal ducts, 10; by nose, 18; by gums, 10; by cheeks, 3; by mouth, 4; by bronchial tubes, 24; from stomach, 32; by the breast, 25; by the axilla, 10; by the umbilicus, 5; by the bladder, 8; by the bowels, 10; by the hands, 7; by the lower limbs, 13; by various regions, 8. In young girls subject to vicarious menstruation the genitals are always moist with a muco-sanguinolent matter at the time of their courses.—*Cincinnati Lancet*, October 3, 1885.

The Treatment of Asthma.—Dr. C. G. Roehr, of Milwaukee, writes to the *Medical Record*, that he has successfully treated a number of cases of asthma by means of anti-epileptic remedies. He was led to institute this mode of treatment from observing that most of his asthmatic patients presented a decidedly neurotic history. He asks that others try this method in those cases of chronic asthma in which there is a family history of neurotic affections.

Lubar Nephrectomy.—Mr. Clement Lucas operated in Guy's Hospital, on October 20th, for a large hydronephrosis occurring in a woman, aged 35, who had been tapped, with temporary relief, in the spring. The tumor was exposed by the oblique crucial incision practised by Mr. Lucas, and removed without injury to the peritoneum. The patient suffered little from shock, and has had no subsequent pyrexia. A week after the operation she was far advanced towards recovery, having had no symptom to cause anxiety.—*Brit. Med. Journ.*

The Reach of Quackery.—There is nothing, short, perhaps, of actual damnation, which some people will not believe quack medicines can prevent or cure. Just now in papers in Maine and other places exposed to the small-pox we find an advertisement alleging that "a sure preventive" of small-pox may be found in a certain quack doctor's pills.—*Med. Record.*

Medical Items.

Since the commencement of the small-pox epidemic in Montreal 2,641 deaths from this disease have occurred.

Dr. James Simons, a retired surgeon U. S. Army, died in this city on November 11th, at the age of 69 years.

Dr. Charles E. Caldwell has been elected Lecturer in General Pathology in the Cincinnati College of Medicine and Surgery.

Lady Sadlier founded the Croonian Trust in the year 1700. The property then bequeathed has so increased in value that it now affords an available income of over 200£ a year.

Professor Virchow has recently asserted that "no specialty can really flourish which cuts itself entirely off from the great body of the science."

The New York State Medical Association held its second annual meeting in New York on Tuesday, Wednesday, Thursday and Friday, November, 17th, 18th, 19th and 20th.

The late Mr. John P. Howard, of Burlington, Vt., has left about $250,000 to be divided between some seven charitable institutions, six of which are located in New York city and the seventh in Burlington, Vt.

The *Medical Times and Gazette* says a number of more or less authenticated cases of hydrophobia flock to the laboratory of the Rue d'Ulm, and if M. Pasteur had the *commercial* spirit of a Dr. Ferrán he might easily start a flourishing practice.

"Luminous doctors' signs are prominently advertised in the pages of a contemporary. That is just the kind of doctors who run the least to such things. As a rule, it is where the "inward and spiritual grace" least abounds that there is the greatest ostentation of the "outward and visible sign."—*Boston Med. and Surg. Journ.*

The *Medical Record* gets off the following:

Said Koch: "I've some comma bacilli."
Said Klein: "I don't think they will kill." "I"
Said Finkley (and Prior),
"Believe he's a liar."
Said Ferrân: "I can knock you *all* sill i."

The New York Charity Organization Society proposes to hold a meeting to consider the existing abuses and misapplication of medical charity in order to determine how these abuses may be remedied. This would be a good move for a Charity Organization Society of Baltimore.

The *Boston Medical and Surgical Journal* says: A medical man in England recently objected taking the judicial oath in the ordinary form, to wit, by kissing the testament, on the score of uncleanliness and risk of infection. The judge refused to entertain this as a "conscientious objection" within the meaning of the act. The witness at length complied under protest. One is inclined to sympahthize strongly with the compunctions of the witness on reflecting upon the number and miscellaneous character of the osculations performed upon the volume in an average court-room.

The Baltimore Academy of Medicine is one of the few medical societies in this country which has more money in its treasury than it knows how to use for scientific purposes. At its recent meeting a resolution was adopted authorizing the Treasurer to remit the assessment for annual dues for the current fiscal year. All of the expenses of the Academy for the year will be paid out of its accumulated funds. This fact shows that the Academy has a most efficient Treasurer, and a liberal and prompt membership, but we cannot but think that it would have been far more creditable to the Academy to have appropriated its surplus funds to purposes which have in view the promotion of scientific work among its members or in the general profession. The Academy now offers an annual prize of $50 for the best paper read by a member. It would have redounded to its interest and fame if it had expended a large sum in founding an Annual Lectureship.

Original Articles.

THREE CASES OF REMOVAL OF THE OVARIES AND FALLOPIAN TUBES (TAIT'S OPERATION).*

BY W. W. KEEN, M. D.

Professor of Surgery, Woman's Medical College of Pennsylvania, and Senior Surgeon to St. Mary's Hospital, Philadelphia.

The following cases are put upon record as a contribution to an important operation, the usefulness of which is assured in certain cases, but the limitations of which have not yet been perfectly well defined.

CASE I. — UTERINE MYOMA; EXCESSIVE HEMORRHAGE AND ANÆMIA; TAIT'S OPERATION; RECOVERY AND CURE.

Mrs. L., of New Jersey, æt. 42; married at twenty-eight; two children—the last born ten years ago; each eleven pounds; normal labors; no miscarriages; absolutely well and strong till three years ago, when her periods became gradually more prolonged and profuse. Now she is unwell three weeks out of every four and the flow is often so severe as to saturate a napkin every fifteen minutes, besides large clots of blood. She is thoroughly blanched, weak, and anæmic.

November 25, 1881. Sent to me for consultation by Dr. Hollingshead. A tumor is visible in the hypogastrium the moment she lies down, and the abdomen is exposed; sound enters 6¼ inches. The tumor is an interstitial myoma in the posterior wall, as large as a large fist, moderately tender and painful; no vegetations on the endometrium; no erosion of os; cervix not involved; uterus movable. Advised Squibb's extract of ergot (♏ xxx-xl), hypodermatically, daily in the abdominal wall for a month; if not then better, advised Tait's operation, as all other means had been previously tried by her attending physician. She was unwell at the end of November, when the ergot was first used. It gave rise to great pain and considerable local inflammation, with nausea and vomiting, and had to be discontinued.

December. Again unwell; the intermenstrual period was freer from pain; but she was weaker and more blanched, and not able to come to the city; lost a large quantity of blood.

January 26, 1882. Came to the city; was so blanched that had she closed her eyes and folded her waxy hands she could easily have been mistaken for a a corpse; weight one hundred pounds. Treatment: iron, quinine, milk-punch; food every two hours.

28th. Taken unwell; period lasted until February 2; used twenty-eight napkins, besides passing a number of large clots. Bad neuralgia of face; morphia (⅛ grain), hypodermatically, failed to relieve, but water similarly given lessened it. Eats but little on account of pain.

February 3. Dr. R. P. Harris saw her with me, and concurred in advising the operation. Temperature 98.5°; pulse 80 feeble; heart normal, but weak; no change in uterus.

9th. Operation 12 M.; antiseptic method with carbolic acid, including the spray; bladder emptied. Duration of operation forty-five minutes. Ether (f℥vijss) used; incision four inches long in median line from pubes half way to umbilicus; no vessels tied.

On opening the abdomen a moderate amount of serum escaped. On account of the high position of the uterus the ovaries were readily found. Each pedicle was transfixed with a double carbolized silk ligature close to the uterus, the upper including the Fallopian tube, and after ligature the tubes and ovaries were removed. The left ovary showed a recent corpus luteum; it had a few small cysts, and was cirrhosed in part. The right had one cyst two inches in diameter, and several smaller ones. The right tube was cystic just at the cervix uteri; it contained a serous fluid. The veins were very large; no bleeding requiring a ligature occurred. The ligatures were all cut off short; four deep and two superficial sutures, the former, including the peritoneum, closed the wound. Dressed with carbolized gauze.

*Read before the College of Physicians of Philadelphia, November 4, 1885.

Immediately after the operation her pulse was 120, and feeble. Hot-water bottles were applied, and brandy was used, hypodematically, several times with good effect. She vomited only once up to 3.30 P. M., when her pulse was 93; temperature 97.2°; very small quantity of food and stimulants every twenty minutes. 7 P. M., pulse 100; temperature 99.5°; has had some pain; feels stronger. 11 P. M., temperature 100.8°.

10th. Slept but little, but is comfortable; temperature 100°.

11th. Temperature 98.4°; considerable pain in the back at 9 P. M. last night, followed by a bloody vaginal discharge. In twenty-four hours has used sixteen napkins, moderately saturated. Water at 105°—110° ordered, which gave relief.

12th. Has used twelve napkins; temperature 98.8°.

13th. Slept excellently; discharge has ceased; dressing changed (fourth day). It was barely soiled, with very slight oozing from the operation; no pus; wound free from blush; union by first intention throughout; meat allowed.

15th. Several enemata having had no effect, as she felt uncomfortable, the rectum was emptied, mechanically, of a large amount of impacted scybala.

19th. Redressed; wound healed; sutures removed.

22d. Sat up.

25th. The menstrual period was due on 24th. Has used two napkins to date; less than fℨss blood on each.

March 17. Went home; weight 110 pounds.

24th. Menstruation due; had some backache; no blood; staid abed three days.

June 6. Came to see me; brown as a berry; weight 130 pounds; appetite good; strength nearly regained; each month had had slight malaise; no bleeding; uterine cavity three and three-quarter inches; myoma not perceptible, except by bimanual examination.

March, 1884. Rapidly regained full strength; weight has continued at 140 pounds; no bleeding; sexual appetite unimpaired; tumor entirely gone; uterus three inches.

CASE II.—SEVERE NYMPHOMANIA, LEADING TO INCIPIENT INSANITY; MENORRHAGIA; TAIT'S OPERATION; RECOVERY; CURE.

Mrs. B., of New Jersey, æt. 42, American; eight children — last born eight years ago; operated on by me, successfully, four years ago for lacerated perineum, and later, another operation for severe hemorrhoids. Wife of a poor, ill-paid clergyman, and hence her life was a constant struggle properly to feed and clothe her large family. I have known her from childhood. She was always a most exemplary Christian woman.

Her head began to trouble her not long after the first operation, and she attributed it to the ether, which, however, she bore perfectly well in both operations. She had strange feelings as if unconscious, and in a fright or dread of ether, especially at night. Exposed to the sun, in August, 1881, she had an attack of heat-exhaustion, followed by a second attack a week later. After this her menstruation, always previously easy and regular, ceased for three months. During this time she was treated for malaria, and her head became worse, which she attributed to the quinine. She became very nervous and sleepless; lost all self-control; could not bear any noise of the children, the church-bell, or even her own voice. She became unable to do any work, and had extreme depression of spirits; attempts at suicide were repeatedly contemplated and though almost determined to end her life, she was deterred by her religious fears. These emotions were readily confessed to me and to her husband. In December, 1882, her menstruation became very profuse, and was continuous for three months. Since then it is not continuous, but is still very profuse.

Meantime, in October, 1881, by spells her sexual appetite, till then a matter of little moment, became immoderate. Day and night it was an exquisite physical and mental torment, and even led her to repeated self-abuse when it could not be gratified. This nymphomania and her head symptoms were always worse at her menstrual period. Finally, she went

voluntarily to an insane hospital in March, 1882, being utterly unfitted for her household duties, and in constant dread of suicide; but soon returned home.

January 2, 1883. I saw her; head still as described, and she was almost desperate; uterus normal, except some erosion at os, and freely movable; clitoris and other generative organs normal. Her attacks of nymphomania were still frequent and severe, especially during menstruation. She was fast passing toward permanent insanity. She loathed herself for her abnormal sexual appetite; she had struggled against it, as well as against her suicidal intent, till she was ready to hail anything that gave the faintest hope of relief at any risk to life, for which she cared absolutely nothing. She had been under varied and excellent care, and every moral means and all promising drugs had been freely tried. I therefore proposed Tait's operation, to which she and her husband instantly assented.

4th. Operation; ether; antiseptic method (carbolic acid), with spray; bladder emptied; incision three inches median line upwards from pubes; layer of fat (she was well nourished) one inch thick, belly-wall two inches. Left ovary found without difficulty; its pedicle pierced by needle with eye in the point carrying a double carbolized silk ligature; ovary and Fallopian tube tied separately and ligatures cut short. One ovarian vein was varicose and as large as the little finger; ovary and tube both removed. Two pedunculated growths of the size of peas were attached to the ovary, one directly and another from the middle of a long foot-stalk attached at the two ends to the ovary and to the tissue between the ovary and tube. The right ovary was found with some little difficulty; as it was pulled out of the wound a small cyst burst. It was treated precisely as the left, and tube and ovaries removed. Both tubes and ovaries were intensely congested (her last menstruation was five days past); several small cysts existed in each.

Her recovery was uninterrupted. She had a little bilious vomiting and retention of urine requiring the catheter, but no pain; and no medicine.

8th. A moderate vaginal hemorrhage began, which ceased four days later spontaneously.

9th, 11th, and 14th. The stitches were removed. Her highest temperature was 99.4°.

19th. Down stairs.

23d. Went home. Since then I have seen her repeatedly; the last time in the spring of 1885. Her mental symptoms and head troubles have gradually become better. For the first six months or more she was often despondent, but she gradually recovered her cheerfulness to a large extent, resumed her household occupations, and is perfectly well. The nymphomania ceased from the time of the operation, save two very slight and short attacks. Coitus is rare, but is entirely normal, and is not followed by any tendency to her former deplorable condition.

CASE III.—UTERINE MYOMA; SEVERE AND LONG-CONTINUED HEMORRHAGE; OPERATION; DEATH.

Miss W., æt. 40, first menstruated at fourteen, always profusely. For the last seven or eight years much worse, the flow continuing ten to fourteen days. In May, 1884, she began to suffer from continuous hemorrhage, which has persisted till the present date, January 2, 1885. Occasional severe hemorrhages also occurred. She is very pale and anæmic, with waxy lips, and has also lost much flesh and strength, especially of late. To-day I examined her under ether: uterus three inches in length, and movable; a myoma as large as the fist was discovered in the anterior wall and fundus. Hypodermic injections of Squibb's ergot, in f℥j doses, every second day, were used, to which, later, and added f℥j of the fluid extract of ergot daily, with tonics and good diet.

January 29. Has passed the menstrual period without noticeable hemorrhage, and to-day, for the first time since last May (excepting two days), has dispensed with a napkin. From this date till April her menstruation ceased. In April

and May she had a normal discharge. But in June the hemorrhage returned, and continued so profusely as to threaten life.

July 4, 1885. The hemorrhage having been checked for three days by the above means, I operated. The tumor, which had clearly increased in size, was immediately seen on uncovering the belly. Ether; antiseptic precautions, including the spray (carbolic acid); bladder emptied. The enlarged uterus was so much in the way that the ovaries could not be seized through the small incision first made in the linea alba, the ovaries not having been carried up with it, and it had to be prolonged one inch above the umbilicus. The whole hand had to be introduced, the uterus lifted and pushed forcibly and the ovaries were even then reached with the greatest difficulty, and after several attempts. The ovary and tube on each side were removed, the pedicle being tied with stout carbolized silk, which was cut off short.

The left tube was attached to the ovary at the fimbriated extremity; two cysts, one filled with blood and one with serous fluid, existed in this ovary, the stroma of which was largely cirrhosed. One large (size of English walnut) and one smaller serous cyst were found in the right ovary, and its stroma was atrophied and cirrhosed. All four cysts were ruptured during removal. About eight ounces of serum were found in the peritoneum.

5th. The wound was united with silver wire sutures after careful cleansing of the peritoneal cavity (there was no bleeding), and then dressed with carbolized gauze. Symptoms of peritonitis began to develop, and in spite of all remedies progressed to a fatal issue on July 7. The temperature was 102°—103° till shortly before death, when it rose to 106°.

Autopsy, July 8. Recent lymph was found over a considerable portion of the belly contents, with an ounce of pus in Douglas's cul-de-sac. No hemorrhage had occurred.

SOME USES OF COCAINE IN GYNECOLOGY.*

BY CHAS. HERMAN THOMAS, M. D., OF PHILA.

Seldom does a new drug reach so sure a place in the confidence of the medical profession as that accorded to cocaine. I early began its employment in ophthalmic practice and soon extended its use to a variety of gynecological applications. The results obtained have been so satisfactory that I now never go to such a case without cocaine in my bag or pocket. After considerable experience in its use I am convinced that it is quite as valuable in the latter case as in the condition for which it was originally recommended. That it is a local anæsthetic when applied to mucous surfaces is a familiar fact, but its property of reducing inflammation and engorgement of the same class of tissues is not so generally recognized, notwithstanding that is a point of considerable practical importance. This action of the drug is readily verified by observing the marked paleness and shrinkage which follow in a few moments after its application to surfaces thus affected. While this condensation of tissue is to a considerable degree temporary it seems to be of longer duration than the accompanying anæsthesia. In some cases the good results obtained by reducing hyperæmia in this manner appear to be permanent. The common fear that it will fail to prevent pain may usually be overcome by placing a few drops of the solution on the tip of the patient's tongue when the numbness produced seldom fails to induce full confidence in its efficacy. Cocaine hydrochlorate is the salt upon which my experience is based.† A four per cent. solution grs. iif (2½) to 3j in water acts well for most purposes, though a somewhat weaker or stronger one may sometimes be substituted with advantage. The addition of boracic acid in the proportion of grs. ij to the 3j insures sterility of the solution.

*Read before the Obstetrical Society of Philadelphia, November 5, 1885.

†The price has been reduced to 10 cents a grain or less.

When used it should be applied with thoroughness, the parts being first freed from mucus and some minutes allowed to elapse for its effects to develop; the time should be *not less than two minutes*, and in cases where considerable pain is to be anticipated, a strong solution, 10 per cent. or more, may be employed, and the application repeated after an interval of two minutes, and in five minutes from the beginning the full effects of the drug may be looked for. That the anæsthesia produced by cocaine is complete I have personally experienced, having made use of a four per cent. solution by injection into the nostrils previous to an application of the galvanic cautery to the nasal cavity. The cautery had been applied on a previous occasion without cocaine and the pain was severe. With it not the slightest pain was felt and I was conscious of the action of the cautery only by the hissing sound produced.

I have found it particularly valuable in certain cases of cervical endometritis in which, though there may be no erosion externally, and but little characteristic discharge, there is a state of extreme sensitiveness existing about the region of the internal os-uteri, a probe or cotton easily bringing blood, and any application made to the part is liable to produce bleeding and severe radiating and ovarian pain. Cocaine carefully applied with the syringe or the cotton-carrier prevents the pain and bleeding which would otherwise follow the necessary medicinal application; the swelling being also materially reduced. The congestive or inflammatory stenosis which usually exists is consequently for the time relieved and applications to the part itself as well as to the entire endometrium are greatly facilitated. In urethral caruncle sensibility may be so destroyed that the painful excrescences may be clipped off and the site painlessly cauterized. Cocaine is also extremely useful in painful irritation and inflammation of the female urethal tract, and especially of the part just within the meatus, a condition attended with distress frequently referred to the bladder. Appropriate medication is painlessly made after its application which may be conveniently made by means of the glass medicine dropper. As a means of preparation for the operation of stretching either the urethra or the cervix uteri it is of unquestionable value. To precede the application of caustic to a chancre it is also effective. I am informed by my friend, Dr. Levis, who has had a large experience with the drug, and who uses it extensively and with great satisfaction, that in plastic operations upon the vagina where considerable surfaces are to be flayed the cocaine anæsthesia is insufficient to prevent pain. It has been recommended in dysmenorrhœa, and there is good reason to believe, from several reports which have been made, that it is capable of producing excellent results when applied to the os-uteri and to the cervical cavity by means of a small cotton tampon. I tested it recently in a case of uterine colic, using it hypodermically in two doses of one grain each, about half an hour apart, but without appreciable relief. It has been tried internally in doses of one grain or more in the vomiting of pregnancy and has met with some favor, but in the only case within my own knowledge it entirely failed.

In a case of vaginismus brought by a practitioner from a neighboring city, the condition was quickly relieved by the local application of cocaine and a complete examination was easily made when, without its use, general anæsthesia would have been necessary. In a case of hyperæsthesia of the vagina with mild vaginismus in which frequent local treatment was required, a suppository containing one grain of cocaine introduced into the vagina a half hour before each treatment entirely abolished the spasm and rendered the introduction of the speculum easy and comparatively painless. Cocaine suppositories also produced excellent results in a case of rectal tenesmus after opium had proved insufficient.

Cocaine has been recommended in operations for lacerated cervix and for the crushing of stone in the bladder. I have not made use of it in either of these applications, but stongly believe in its value.

In one hyperæsthetic patient in whom violent pain was developed on slight provocation, and who required local treatment of the cervix uteri and urethra, but who suffered so much from ordinary applications that the local benefit was fully counterbalanced by harm done nervously, it became necessary to suspend treatment on this account. After cessation for six months treatment was resumed under cocaine, and it has since been in every way satisfactory. The pain formerly produced by applications to the cervix is now entirely absent. In the same patient painful irritability with spasm of the bladder simulating cystitis, which was not entirely relieved by the opium suppository and other measures, yielded completely and thus far permanently to a single injection of one grain of cocaine thrown into the bladder. The resumption of treatment in this instance was largely due to the enthusiastic approval of the husband, who had himself experienced complete relief from the injection of a dram of the two p. c. solution into the deep urethra for a violent urethrismus. In another instance in a woman with irritable piles, red as a ripe strawberry, and who was suffering extreme discomfort, the piles shrank and turned pale under the cocaine application and were then painted with tincture of iodine with entire absence of pain.

Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD NOV. 5, 1885.

The President, B. F. Baer, M. D., in the Chair.

(*Concluded from page* 70.)

Dr. William Goodell exhibited the ovaries from two cases of oöphorectomy with the following histories:

OÖPHORECTOMY FOR OVARALGIA.

When the patient, an unmarried woman, aged 30, first consulted him, she weighed 236 pounds, but at the same time she was very weak and could barely walk. She suffered excessive pain at her catamenial periods, which appeared only at long intervals. She had cataleptic and hystero-epileptic fits and complained of very constant and acute ovarian pains. Her urine was passed but once a day and this act was attended with much suffering. The womb was enlarged and the ovaries were very tender indeed, but nothing else abnormal was discovered. Assafetida and the bromides were prescribed in large doses and she was advised to try the rest treatment. Fourteen months later she was again brought by her physician to consult Dr. Goodell. She now weighed only 120 pounds, having lost 116 pounds, and she was in every respect worse, her ovarian pains being now constant and very acute, requiring large doses of morphia to control them. Her catamenia had not appeared for nigh four months, and tonics seemed to have no effect whatever on her. Her physician was compelled to be in constant attendance on her and was liable to be summoned at any hour of the day or night to give her a hypodermic injection. Masturbation was suspected, but she always denied practicing this habit. Nothing further could be done than the operation of oöphorectomy, which was accordingly performed a few days later at the hospital of the University. The ovaries were found much enlarged from cystic and interstitial degeneration, but there were no evidences of peritonitis or of cellulitis which had been suspected. A corpus luteum existed in one ovary, a rectal hemorrhage or vicarious menstruation having taken place a few days before the operation. Her ovarian pains at once left her; she needed but very few doses of opium, which was given by rectal suppositories. Her convalescence was prompt and she returned home in less than four weeks free from all pain, and in a fair way to get perfectly well. The case was a typical one of the advantages of oöphorectomy. Yet he (Dr. G.) thought that the operation was being performed altogether too frequently.

OÖPHORECTOMY FOR BLEEDING FIBROID OF THE WOMB.

In this case the lady was thirty-seven years of age and had been married eleven years. She gave birth to a child about seven years ago, and since then has had one premature birth at seven months, and one miscarriage. She first noticed an abdominal tumor nine years ago, but her catamenia began to be free some time before this. Late in the year 1881 the catamenia began to be excessive. As nothing served to check them, early in the following year Dr. Goodell was consulted. He found multiple fibroids of the womb. Six tumors could be readily made out, of which two seemed pedunculated; the sound gave a measurement of 4.5 inches. Under ergot and ammonium chloride the patient improved for several months, then the menorrhagia became worse and finally a dribbling of blood kept up between the periods. In May of the present year she again consulted Dr. Goodell. She had been dribbling continuously from January and was much reduced in strength. Being a brunette she exhibited the facies uterina in a most marked degree, the pigmentation being very dark and extensive. The womb now measured 7.5 inches. She was admitted into Dr. Goodell's private hospital, and on May 24th both ovaries were, without difficulty, removed. They were greatly enlarged by follicular degeneration, a condition which Dr. G. had repeatedly seen in cases of fibroid tumor. The effect of the operation on the tumors, and especially on the main one, was astonishing. After two weeks this fibroid had diminished in length nearly a hand's-breadth. Her recovery was prompt, and she was sent to Atlantic City to recruit. On July 10th, just forty-seven days after the operation, she called on Dr. G., who found the tumors very greatly reduced in size and the uterine cavity measured only 3.25 inches, a diminution of 4.25 inches. This extraordinary amount of diminution, in spite of the fact that the obliteration of the ovarian blood-vessels cut off only a small portion of the blood supply to the womb, drove him to the conclusion that the ovaries were important factors in inviting blood to the womb. Every successful case in which he had removed the ovaries for fibroid tumor of the womb had been followed by the menopause and by rapid diminution in the size of the tumor. But in his hands and in those of others the operation was more fatal than that of ovariotomy. During the ten months of the present year he had had twenty-five cases of ovariotomy with but one death, and that one in a lady operated on at her home, two hundred miles from Philadelphia. For simple cases of oöphorectomy the mortality should not be greater than that of ovariotomy. But when complicated with the presence of a large or an adherent fibroid tumor, the operation is often one of great difficulty. Twice during the past year he was unable to reach the ovaries and was compelled to abandon the operation, because in neither case was the woman willing to undergo the risk of having hysterectomy performed. Each case recovered, and while the women were under observation the tumors appreciably lessened in size, as if the shock of the exploratory incision had temporarily suspended the ovarian influence.

Dr. Montgomery was glad to hear the good results in Dr. Goodell's cases. In a few of the cases upon which he had operated, the menopause did not at once occur, sometimes not for two years after the operation. In such cases the tumor did not decrease in size while menstruation continued. In the case of hysterectomy for fibroid tumors reported by Dr. Montgomery at the last meeting, temperature at no time exceeded $101\frac{5}{10}^{\circ}$, and the patient left the hospital to-day perfectly well. He preferred removal of the uterus and its appendages entire when the ovaries cannot be removed in consequence of previous inflammatory changes. Ligation of blood vessels supplying the tumor might be useful, when nothing better could be done.

Dr. Baer thinks that when the ovaries can be removed it is the preferable operation.

Dr. Goodell has been so uniformily successful in removing the ovaries for

the cure of fibroid uterine tumors that it is his choice. He has been notified that in a case of fibroid tumor of the womb in a woman aged thirty-three years, he will be called in consultation; this will be the third. He will advise removal of the ovaries, if at the time of operation that is not found possible he will close the incision, as the other operation is very dangerous, and the patient can certainly live a few years as she is. In one case only of his oöphorectomies has the menses continued, and he thinks that in that case there must have been some supplementary ovarian tissue.

OVARIOTOMY.

Dr. Montgomery exhibited for Dr. Warder a large ovarian tumor, and related the following history:

The patient was a young woman. Her menses commenced at 17 years of age and had always been irregular. They ceased entirely for twelve months and at the same time the abdomen was enlarging until the tumor reached above the navel. Fluctuation was doubtful; the mass seemed quite solid and pressed the uterus down into the pelvis. Anæsthesia did not relax the abdominal wall, and diagnosis was doubtful. An exploratory incision, showing the pearly tint of an ovarian tumor, made it sure. Nothing would pass through the trocar, but some of the jelly-like contents of the tumor escaped beside it and passed into the abdomen. The large cyst was filled with small cysts. The patient did well for one week, then the pulse became rapid; but she has since been doing well and is now rapidly recovering.

Dr. Goodell thinks the danger from the escape into the abdomen of cyst contents is overrated.

Dr. Baer. In the early stage of ovarian tumors metrorrhagia is sometimes present; sometimes the menses are entirely absent. He should like to hear from the Society some reason for this inexplicable difference.

Dr. Goodell has observed the same facts, but can throw no light upon it.

Dr. Montgomery remarked that in this case both ovaries had undergone cystic degeneration. The second ovary contained numerous small cysts.

Dr. Baer inquired about the treatment of the second ovary.

Dr. Montgomery replied that it was removed.

SOME USES OF COCAINE IN GYNECOLOGY.*

DISCUSSION.

Dr. Keating has used cocaine for some time in the same class of cases. He now uses eight per cent. solutions with great success, especially in children's throats. He employs salicylate of cocaine in diphtheria in a five or six per cent. solution; sensibility disappears in a short time, and he can then use any application without discomfort; he applies carbolic acid, tincture of iodine, &c., in this manner without exciting pain. He also applies cocaine before injecting carbolic acid into piles and also applies it on cotton to prevent its action ceasing too soon.

Dr. Thomas said that the strength of the solution may, with propriety, be greatly varied, and that in his practice upon the eyes even a one per cent. solution was strong enough to be of considerable value in conditions of irritation produced by foreign bodies in the eye; but in other cases, as urethral caruncle, it might be well to use it even in saturated solution.

The question of strength is largely a question of expense, for in local application no toxic results are likely to be produced.

BALTIMORE GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY.

FIRST REGULAR MEETING, HELD NOVEMBER 10, 1885.

The President, GEORGE W. MILTENBERGLR, M. D., in the chair. WM. E. MOSELEY, M. D., Secretary.

Dr. H. P. C. Wilson, represented two cases upon which he has recently operated and exhibited the specimen.

*See page 80.

SUB-MUCOUS FIBROID OF UTERUS.

Case I. Mrs. M., age 49. Married 27 years. Has had 7 children and one abortion at six months. Her last pregnancy occurred 9 years ago. First menstruated at the age of 12, but the flow did not again appear until after an interval of 3 years, after which it was regular. Has been bleeding from the uterus most of the time for the past three years, and since April the flow has been constant and accompanied by severe bearing down pains.

Examination showed a fibrous polypus presenting at the external os and completly filling it. Three weeks ago, under chloroform, the os was dilated by means of Dr. Wilson's heavy steel bivalve dilators, and it being found impossible to pass the chain of an écraseur over the growth, it was cut off close to the uterine wall with heavy serrated scissors. The cavity of the uterus was cleansed with carbolized water and the stump wiped over with Monsel's solution diluted with two parts of glycerine. Dr. Wilson said he used this principally on account of the antiseptic properties of the iron solution. The growth was of an oval shape 2½ and 3 inches in its diameters and was nearly sessile, the base measuring 1½ inches in diameter.

The patient made a good recovery but it will take a long time to regain the amount of blood lost.

In exhibiting his dilator Dr. Wilson said he had it made for dilating the uterus, during the early months of pregnancy, as after abortion. He found it to answer the purpose very well.

AN EXCEPTIONALLY LARGE VAGINAL CYST.

Case II. Mrs. C., age 30. First menstruated at 16. Has been married 14 years and has had 7 children, but no abortion. Last labor 7 months ago.

The patient was sent to Dr. Wilson as a case of prolapse of the bowels. Examtion showed a cyst of the posterior vaginal wall, about as large as a goose egg, completely blocking up the vulva and containing about four ounces of fluid of the consistency and color of flaxseed tea. The patient was also found to be about two and a half months pregnant. Dr. Wilson said he had seen many cysts of the vagina, but this one was by far the largest, and with one other exception, all had grown from the anterior wall.

The diagnosis having been made certain by the use of a hypodermic syringe, the cyst was removed by cutting around its edge at the level of the vagina. The operation was done under chloroform. Bleeding was so free as to necessitate the tying of four arteries. The surface of the base of the cyst was wiped over with Monsel's solution and glycerine, and the vagina tightly tamponed with cotton soaked in glycerine overlayed with dry cotton. The patient made a good recovery without aborting.

Dr. B. B. Browne asked Dr. Wilson if the membrane left after the removal of the cyst was mucous membrane.

Dr. Wilson said he was certain a mucous surface was left. He made no effort to dissect out the base of the cyst as the iron application would destroy its secreting power.

Dr. L. E. Neale asked Dr. Wilson if he understood him correctly as saying that he used the iron solution principally as a local antiseptic. That although this use of the iron had been suggested, yet, when used alone it was a powerful coagulant and styptic, even producing disagreeable sloughs, and for these reasons he thought that, when the principal desire was for local antiseptic, we possessed other means that were preferable.

Dr. Wilson said he considered Monsel's solution a specially good antiseptic. He always uses it freely in combination with glycerine in the surgery of the cavity of the uterus and in the vagina, when union by first intention is not desired.

Dr. Thomas Opie said he thought the use of metallic dilators questionable in obstetric practice. He preferred to use Molesworth's dilators in the cases alluded to by Dr. Wilson, because they were less apt to injure the tissues of the cervix, and were more in accordance with Nature's plan, which was to dilate with a water-bag. Another objection to me-

tallic dilators was the immediate rupture of the membranes.

Dr. Wilson thought his metallic dilators specially adapted to those cases in which dilatation has to be artificially begun, and to carry it to a point where the rubber bag dilators can be used. From this point the latter should be used in preference to any other means.

Dr. W. T. Howard said, that, when a large fibroid polypus is lying partly intra-uterine and partly intra-vaginal, or wholly in the vagina and completely fills the canal, he has long used a pair of forceps, devised by the late Dr. W. L. Atlee, for the purpose and draws the tumor down, sometimes outside of the vulva, and severs the pedicle with serrated scissors. The hemorrhage is seldom great. In one case at the University of Maryland Hospital, witnessed by Dr. Ashby, when he was resident physician there, the fibroid filled the vagina so compactly that it was impossible to pass the wire rope of the écraseur around it, or even beyond the equator, when a few turns of the scew usually suffice to carry it down to the pedicle. In that case, after delivering the polypus beyond the vulva with Sir James Y. Simpson's forceps, for it was larger than a fœtal head of average size, as the attachment was at the fundus, the uterus became inverted, but it was easily reduced. During the removal of this growth, which was then pulled down by a strong vulsellum forceps passed high in the vagina, one of the teeth of the instrument caught in the anterior vaginal wall and made an opening in the bladder about an inch long; but the fistula was easily closed after the removal of the vaginal tampon.

When a fibroid polypus is attached to the fundus uteri or high within the cavity, it is often extremely difficult to pass a wire loop around the stalk. To accomplish it with less difficulty, Dr. Howard has devised an instrument, made of copper and silver-plated that it may be easily curved to any desirable degree, similar to Sims' feeder, but much larger. He has found this instrument very useful in some difficult cases.

He agreed with Dr. Wilson that the *liquor ferri sub-sulphatis* has marked antiseptic properties. Indeed, he was the first in this city to direct the attention of the profession to that fact, as will be seen by a report made from the Section on Obstetrics and Gynæcology to the Medical and Chirurgical Faculty of Maryland, in April, 1875. But after operations within the cavity of the uterus, he much prefers the application to the bleeding surfaces of Churchill's tincture of iodine, which has the great advantage over iron of not producing hard blood-clots, etc., and yet possesses strongly marked styptic properties. For years he used the combination of equal parts of Monsel's solution of iron and glycerine with ten grains of carbolic acid to the ounce, which he learned from the late Dr. J. Marion Sims, and it was long known at the University Hospital as Sims' styptic.

In regard to vaginal cysts, he said, it was curious that while Dr. Wilson has only seen them growing from the anterior vaginal wall he had seen two cases within a year, in which they sprung from the posterior wall. As these cysts do not generally produce any symptoms, unless large enough to hinder labor or disturb the functions of the pelvic organs, they are not often recognized, save during examination for other affections. He was surprised to hear Dr. Wilson say that the diagnosis of the case, he reported, was difficult. He had supposed that diagnosis was easy in such cases, when attention had once been directed to the affection, by conjoined examination of the vagina and rectum. It is true, as Dr. Wilson had stated, that a vaginal cyst may present the appearance of the serous coat of the bowels; but the latter could not appear in the vagina unless through a rent induced by a severe traumatism, as the vagina is a musculo-membranous tube pervaded everywhere by elastic elements, and possesses great strength and toughness. Were it otherwise it would be constantly lacerated during labor. Nor, even in cases in which vaginal cysts are observed in connection with bad laceration of the perineum, involving the sphincter ani, should diagnosis be difficult, as the mucous membrane of a prolapsed rectum contrasts strongly with

the bluish-gray appearance of a vaginal cyst.

When the removal of vaginal cysts is attended by hemorrhage from bleeding vessels, as in Dr. Wilson's case, it is much safer to rely upon strong, firmly tied ligatures, than upon the pressure effected by iron-cotton vaginal tampons. A properly ligatured artery cannot bleed.

When dilatation of the cervical canal is needed, whether after abortions or to facilitate the removal of an intra-uterine growth, Dr. H. much prefers the use of tupelo or laminaria tents, to sudden and more forcible dilatation with steel branched dilators. The latter are apt to bruise and lacerate the cervical mucous membrane and parenchyma if the dilatation is carried to any considerable degree, and thus, after abortions, to present a favorable *nidus* for septic absorption. When it is necessary to dilate the cervix during the latter months of pregnancy, after the seventh, he always injects hot water against the cervix which greatly facilitates the introduction of Barnes' fiddle-shaped bags, with which he has been invariably successful. He considers Molesworth's dilators as much more powerful, and too harsh and rough to be placed in ordinary hands. Moreover, they are generally out of repair and unfit for use when most needed. Ruptures of the uterus by their use have been reported.

In only one case had he seen bad results from the use of sponge tents when used to facilitate exploration of the uterine cavity. He always dips the tents, before introduction, into glycerine and carbolic acid ten grains to the ounce.

Dr. Wilson said he thought no dilator should be used in any uterus except it be dilatable. The reason for the difficulty in diagnosticating the cyst was due to the complete rupture of the perineum. The difficulty was not experienced by himself, but by the physician who sent the case to him.

A NEW UTERINE REPOSITOR.

Dr. T. A. Ashby exhibited a new uterine repositor, which is shown in the accompanying cut.

Dr. Ashby said the instrument could be used upon the same principles as the Sims' and Emmet repositors. In addition it possesses a leverage power which enables the operator to lift the uterus into its normal position by drawing upon a rod, which works in the handle. By the exercise of gentle force, the uterus, when free, may be raised into its normal axis, the operator working with either a bivalve, trivalve or Sims' speculum. If it is desired to use the instrument as a Sims' or Emmet repositor, it may be done by screwing into the disk the straight Sims' stem or the jointed finger stem of Emmet. A long and short straight, and a jointed stem accompany each instrument and are carried inside the handle. Dr. Ashby considers this a perfectly harmless instrument when intelligently used. It presents to the operator the choice of replacing a uterus in three different ways. *First*, by passing the straight stem into the uterus, as is done with Sims' repositor, and, with the finger in the posterior fornix, lifting the the uterus into position. *Second*, by using the finger-joint stem the leverage force of the Emmet instrument may be employed. *Third*, by using either the straight or finger-joint stem, according to the axis of the uterine canal, the uterus may be lifted up by drawing upon the rod in the handle. When used in the latter way, the patient may be placed upon her back or in Sims' position. The stem may be fixed at any angle by

means of a fixation screw in the shaft in front of the finger ring.

Dr. Ashby said the instrument had been in his hands only a few days, but in the few cases in which he had attempted its use he had succeeded in replacing the uterus with decided facility and ease. Upon theoretical, as well as practical grounds, he thought the instrument would answer a most useful purpose in those cases where reposition of the uterus cannot be secured by effect of position or digital manipulation. In other words, in those cases in which an instrument was required.

Dr. Howard said he considered the instrument exhibited by Dr. Ashby very ingenious, but rather too complicated for general use. Some years before his death Dr. Sims materially modified and improved his repositor, and it seems to Dr. H. to leave little to be desired in such an instrument. In October, 1881, in this city, he saw Dr. Sims restore with it a large hyperplastic, acutely retroflexed uterus, of long standing, with exquisite sensibility to the touch, to its normal position, so skilfully and gently that the lady, who was a ready complainer, was not even aware of what had been done. As she was lying on her back Dr. S. carefully introduced the index finger of the left hand into the vagina to guide the slightly curved stem of the instrument into the os externum; then, he slipped the finger into the posterior *cul-de-sac* of the vagina and carefully lifted up the uterus, while he inserted the stem into the organ up to the disk. The uterus was lifted up as high as possible before he began to bring it forward in a straight line instead of a circle, as when the sound is used. As the repositor was withdrawn he caught up the fundus with the right hand and completely anteverted the uterus.

Sims' repositor has one great advantage over that known as Emmet's, as, when the stem (of which there are three from 2¼ to 3 inches long) is fixed in the disk at any desirable angle, the uterus can be pushed backward, drawn forward or turned to either side at pleasure, which greatly facilitates diagnosis in certain cases.

Dr. B. B. Browne thought most uteri could be reposited by digital pressure, and he always followed the plan described in Thomas' text-book. In cases where the fundus is strangulated by the shortened utero-sacral ligaments they may be relaxed by carrying the cervix back with a tenaculum.

Dr. Browne thought intra-uterine repositors were always objectionable and often dangerous; besides in those cases of retroflexion in an elongated uterus an ordinary stem would not reach beyond the point of flexion and so but serve to exaggerate it. He exhibited a specimen of Greenhalgh's modification of Sims' repositor, which acted upon somewhat the same principle as Dr. Ashby's. This repositor was introduced to the profession about seventeen years ago and has been generally discarded as a dangerous instrument. He retained it only as a curiosity and to show students how uteri should not be reposited.

Dr. Howard was pleased to hear Dr. Browne state that he had abandoned the use of Greenhalgh's repositor, sometimes called Gardner's, as, when the stem of that instrument is introduced into the uterus, the various angles that may be desired are given by a screw in the handle. Hence it is impossible to regulate the amount of force exerted as accurately as with Sims' instrument and it is much more difficult to readily manage.

But of late years he finds himself using all intra-uterine repositors far less than formerly, since he has become ac customed to treat patients in office practice on Thomas' table, which gives the distinctive advantages of the genu-pectoral position in the use of Sims' speculum.

Dr. Wilson said that he liked Dr. Ashby's instrument very much but never makes use of any instrument of the kind and does not think that at present he possseses one. Always reduces a retroversion or flexion with the patient on her back. Introducing a small Hodge pessary he applies pressure to the body of the uterus by pressing on the anterior bar of the pessary. It practically lengthens his finger. He considers it

dangerous to attempt to raise a uterus bound down by adhesions, except it be done very slowly.

Dr. Howard remarked that although retroflexions can in most cases be reduced by digital manipulation alone or with Hodge's pessary, these methods are not always effectual as when the flexions are of long standing or there is much thickening and shortening of the utero-sacral ligament, and, also, when the sound indicates a uterus lengthened to four inches or a little less.

Dr. Ashby, in reply to the criticisms on his instrument, said that the objections urged against intra-uterine repositors were quite valid in those cases where the uterus could be replaced by digital manipulation, aided by the position of the patient. There were, however, certain conditions which clearly demanded the use of an instrument, as for example, where the vagina was long and the uterus high in the pelvis, or the finger of the operator too short to be of service. He had not had a long experience with the instrument which he had presented to the Society, as it had but recently been made for him by Chas. Willms & Co., of this city. In the few cases in which it had been employed it had given complete satisfaction. He had but a day or two before seen a patient, in consultation, in whom he found a retroverted womb, fixed and rigid in its false position. With very little effort, and no severe pain to the patient, he had lifted the organ into its normal position, and, then, removing the stem of the repositor, had demonstrated the position of the uterus with the sound. In similar cases he believed the instrument would be of efficient service. It combines in one instrument the special merits of three.

(*To be Continued.*)

Abnormal Mobility of the Tongue, with Ability to Project into the Naso-Pharynx.—Dr. Louis Jurist, Lecturer on Rhinology and Laryngology, in Jefferson Medical College, Philadelphia:—has contributed the following to the *Medical Record*, Thos. P., aged 21, syphilitic, was referred to the Throat Department from the Surgical Dispensary of the Jefferson Medical College Hospital for examination. He had suffered for thirteen years with chronic rhino-pharyngitis, and had been much annoyed by the accumulation and desiccation of mucus in the naso-pharyngeal cavity and on the posterior wall of the pharynx. He often examined his throat with the aid of a hand-glass, and two years ago succeeded, after two months' practice, in reaching his pharynx with the tip of his tongue and removing the masses of secretion. This procedure now became a source of much comfort, and was indulged in daily. On one occasion his tongue slipped into the pharyngeal vault and gave him still better facilities for cleansing. Upon examination, the evidence of an ordinary inflammation of the turbinated tissues, with hypertrophy and subsequent pharyngitis, was well marked. He could with the greatest ease, and many times in succession, project the tip of his tongue into the vault, and described fairly well the posterior septum, etc. A probe passed through the inferior meatus was readily and freely moved.

The frænum linguæ was ruptured in three or four places, and he stated that the under surface frequently felt sore, and that he often heard "cracking" while practising. His tongue, rather pointed, was not of unusual length. Nothing abnormal in the conformation of the naso or oropharynx could be detected. As far as I have been able to discover, but three similar cases are on record. In Dr. C. F. Whitney's case (*Medical Record*, April 28, 1883) the frænum was merely represented by a lax fold of mucous membrane; in Dr. Webster's own person (*Medical Record*, May 26, 1883) "the frænum had never been cut, but the power was acquired with difficulty;" in Dr. J. O. Roe's patient (*Medical Record*, June 9, 1883) "the frænum linguæ was well marked, though a little more lax than usual." Dr. E. Fletcher Ingals, of Chicago, informed me by letter that he had seen one case, but furnished no details.

Curiously enough, the faculty has so far been observed only in males!

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BALTIMORE, NOVEMBER 28, 1885.

Editorial.

INTRA-PULMONARY INJECTIONS OF IODOFORM.—The discovery of the bacillus of tuberculosis by Professor Koch has drawn increased attention to the study of phthisis and has resulted in the investigation of new methods of treatment. Although it has been asserted by so eminent an authority as Dr. Jaccoud that the discovery of the bacillus has been sterile in its effects upon the treatment of phthisis, it may be claimed that the prospects of cure of this disease are by no means as discouraging as formerly. In the use of antiseptic inhalations and of various forms of antiseptic medication we observe an attempt to destroy the specific germ of phthisis which has given more satisfactory results than were formerly obtained. Among the more modern methods of antiseptic medication the one which has for its object the washing out of lung-cavities seems entitled to more than ordinary consideration. Injections into the lung or into intra-thoracic cavities have been performed frequently. As far back as 1867 Professor Wm. Pepper, of the University of Pennsylvania, suggested and employed pulmonary injections in certain phthisical conditions with the view of modifying these conditions. Professor Pepper's method consisted in inserting a small steel cannulated needle, three inches long, attached to a syringe with a capacity of twenty-five minims. Dilute solutions of liquor iodinii compositus, at first in the proportion of one part to fifteen, later of one part to five, were used. The quantity of fluid injected varied from four to twenty-five minims, and the injections were made once a week. Professor Pepper employed injections in seventeen cases with results which were considered satisfactory. Dr. Beverly Robinson, of New York, subsequently made intra-pulmonary injections in eighteen cases after the method employed by Professor Pepper. His results show that these injections, when properly made, are not dangerous and that in certain cases they relieve symptoms, such as cough, dyspnœa and the quantity and character of sputa. The surgical treatment of lung-cavities by antiseptic injections has been employed by a number of different men with a success which should encourage further trial with antiseptic agents thus employed.

In a recent contribution to this subject (*British Medical Journal*, October 3, 1885,) Dr. R. Shingleton Smith, Physician to the Bristol Royal Infirmary, relates his experience with injections into the lung-substance limited to the use of iodoform, which was selected on account of its high germicide value, and its non-irritating qualities. In a series of cases published by Dr. Smith last year, in which iodoform was administered by the mouth, it was found that 29 out of 46 cases showed an absolute gain in body-weight, amounting, in one case, to 32 pounds in 99 days; in another case to 33 pounds in 110 days; of the remaining 17 cases, the loss of weight was small, and in many of them, the wasting which had previously been rapid was more or less completely arrested. Dr. Smith in one case administered as high as six-grain doses of iodoform five times daily, and no toxic symptoms were witnessed till after one month's continuous administration of thirty grains daily; and whilst the limit of administration in most subjects may be below this quantity he has frequently given twenty-five grains daily without producing toxic or deleterious results. Whether it is possi-

ble to introduce medicinally, by the usual methods, such a quantity of iodine as will prevent the germination and growth of the tubercle-bacillus throughout the body Dr. Smith thinks at present *sub judice*. With the local means now at our disposal, he thinks, it will be possible to accomplish the end in view. The treatment by injection into the lung-tissue appears to him to be an easily performed, safe, and theoretically useful method by which local developments of tubercle may be reached by local treatment, and so the risk of toxic effects of iodoform, when introduced into the blood in any quantity, may be avoided. Dr. Smith has practiced the method of injection into the lung with an iodoform solution in five cases. Whilst the results have not been great they have, upon the whole, been encouraging. In all the injections were given 42 times in the five cases. The ethereal solution of iodoform was employed in all except the first four injections. The ether readily dissolves one grain in five minims, but will not take up more than this; accordingly, the quantity of iodoform capable of being injected is limited by the anæsthetic effect of the ether.

In concluding his paper Dr. Smith offers the following remarks, which seem to us entitled to consideration.

"The general result of my experience of these injections may be summarized as follows.

1. No harm has arisen in any one case; there has been no hæmoptysis, no evidence of pneumonia or general pleuritis set up by the injections; no evidence of any irritation or change to the lung-texture, or to the cellular tissue at the seat of puncture. The ether has given rise to a feeling of faintness and giddiness; but these have been only of momentary duration, and have left no ill effects afterwards. Cough has frequently been present during the injection, but has ceased almost immediately. Pain around the side has been present in one case; and in another, pain has been felt extending down from the shoulder, along the arm, in attempting to inject above the scapula behind. Pleuritic pain and friction have been present in two cases; but of a very evanescent character, and not accompanied by any rise in temperature.

2. The positive results obtained have been as follows. In Case I, of lung-gangrene, there was diminution of the fœtor, and general alleviation of the symptoms. In Case II, of chronic pleuropneumonia, with basic cavities, there was diminution of expectoration, and some improvement in general condition. In Case III, of chronic tubercular pleurisy, there was very marked improvement under treatment. In Case IV, there was some little improvement whilst under treatment, but nothing definite as a result of the injections. In Case V, no definite result has yet been observed. Case III was the only one in which improvement could reasonably be expected; in the other cases, the treatment was adopted with no great expectations as to the result.

These cases do not, therefore, go far to establish the utility of intra-pulmonary injections in phthisis and other diseases of the lungs; but they do show that the practice may be looked upon as a safe one, and that it is likely to be of benefit in suitable cases.

I have been unwilling to adopt this method in cases where steady improvement has been induced by other methods of treatment; and, further, when the lungs have been in a hopeless state of excavation, I have also not cared to carry out a practice which could only be looked upon as useless interference; hence the number of cases so treated has been of necessity small; but the results have been encouraging, and I have little doubt that the intrapulmonary injections will become a familiar, an efficient, and a useful addition to our methods of treatment of chronic diseases of the lungs."

How to Build up a Medical Society. —Our contemporary, the *Journal of the American Medical Association*, in commenting upon an editorial, which appeared in the issue of the Maryland Medical Journal, of October 31st, under the above heading, has taken occasion to extend and supplement our remarks in an article which commends itself to all professional readers. There

can be no denial of the fact that the manner in which many medical societies are conducted is open to just criticism, and to correction. We have, previously, urged in our columns the importance of correcting some of the abuses which attach to the work done in our local medical societies, such for example as the careless and indifferent way in which original papers are gotten up, cases reported and specimens exhibited, as also in the impromptu discussions which follow. It must occur to those who attend these society meetings that there is vast room for improvement in the methods of presenting work, and we think, with some effort upon the part of each member, an improvement would follow if the reports of these societies were properly prepared and published. The fact that a speaker's remarks will appear for or against him in print will have a double effect; it will encourage him to prepare well before he attempts to speak upon a given subject, or it will enjoin upon him the necessity of keeping silent if he has nothing worthy of remark. Both of these motives are worthy of encouragement. It is far better to keep silent than to talk irrelevantly upon any subject. On the other hand, encouragement should be given to those debaters who come to a meeting prepared to instruct their associates in facts derived from experience or careful study. Indeed, a society which stimulates original work, the development of an individual experience, or the cultivation of the intellectual faculties by diligent study, is doing a valuable work for its membership, just as one which permits its membership to run wild in careless statement and in voluable discussion is correspondingly lowering the status of its work and usefulness. There must be a reason for the existence of a medical society. The object in view is not purely social or ethical. It seems to us the chief aim is to advance the individual experience, skill and knowledge by the association of ideas, exchange of views, and relation of the experiences of a number of individuals. By cooperation strenth is imparted. But this cooperation cannot reach its full measure of strength unless each individual contributes a proportionate share. What one builds up another tears down unless each contributes to the general fund. Hence the society which stimulates no power of strength is directly encouraging its elements of weakness.

Our contemporary offers the following, which we think worthy of a place at the conclusion of our remarks.

"One point more. Every physician should consider it his duty to belong to at least one medical society; and his second duty is to attend the meeting. Very many physicians seem to regard membership in a medical society as something accidental or incidental to professional life, rather than as a duty which each one owes to himself and his profession. For example, of the forty-three or four hundred regular physicians in Illinois, there are not two thousand who are members of medical societies. This is certainly a very bad showing for members of a "learned profession." But the same is true of almost every State in the Union. For one county in Illinois, with twenty-four regular physicians, we learn that 'there is no medical society in this county. The profession is divided.' The 'divided profession' should remember that a society is for the good of the whole, as well as for the benefit of individual members."

Medical Defence Association.—The interests of the medical profession in this country have not received that attention from the profession itself to which they seem fairly entitled. There are a number of ways in which professional interests may seriously suffer and in which an organized co-operation upon the part of the profession, in the form of a Medical Defence Association, would render inestimable service in protecting and defending these interests. Our attention has recently been directed to this subject by a notice in a late number of the *British Medical Journal*, from which we learn that the Medical Defence Association of England, has recently instructed its solicitors to investigate certain cases of unqualified practitioners with a view to prosecution. An important suggestion was brought to the

notice of the Council of this association having in view the idea of affording assistance to medical men, who are threatened with litigation, or against whom charges of malpractice or other grave accusations have been made for the purpose of extortion. The president of the Council admitted that the association might do a vast amount of good in this direction as medical men often submitted to gross imposition and extortion from fear, and conviction of their inability to get the best legal assistance, except at a ruinous cost, when they would, if supported by their professional brethren, be encouraged to face their difficulties, and come out of the trial satisfactorily. Several well-known cases were cited to show the necessity for such assistance. This idea was considered of such importance, that a general meeting of the members of the association was called for the purpose of altering the by-laws so as to extend the powers of the Council.

In this connection we would urge our readers to consider the advantages of professional co-operation in looking for protection for those interests of the profession which seem just now so depressed by reason of insufficient and inoperative medical legislation in our State. It seems clearly the duty of the profession in Maryland to organize some plan looking to the suppression of quackery in the State, and to the protection of professional rights, when assailed by hostile influences. In matters of professional welfare the motto, "United we stand, divided we fall," is a correct proposition.

How to Preserve Recent Pathological Specimens.—Many valuable pathological specimens are often lost, or rendered useless, by not having at hand some proper, convenient and inexpensive method of keeping them as little changed as possible. The following method, explained by Mr. Lund, at a meeting of the Manchester Medical Society, held October 7, 1885, (*British Medical Journal*, October 31st, 1885), seems worthy of trial. Mr. Lund suggests that specimens be placed in an air-tight vessel filled with the vapor of sulphuric ether, chloroform or ether and creosote, previously mixed with alcohol. Several thick folds of lint, saturated with one of these solutions, should be put at the bottom of the vessel, and the specimens arranged over it in trays, so that the vapor may have free access to each specimen. In this way, he states, the specimens are always ready for examination, without being softened and decolorized by immersion in weak spirit and water or other preservative fluids. The cover to the vessel should be made air-tight, by a vulcanized India-rubber ring, on which the edge of the lid is firmly pressed, or by allowing it to dip into a grove around the top of the vessel, which may be filled with vaseline or still better, with liquid mercury if it is not desired to move the vessel from place to place.

Reviews, Books and Pamphlets.

The Medical News Visiting List. Published by Lea Brothers & Co., Philadelphia. For sale by Cushings & Bailey, Baltimore, Md. Price $1.00.

This Visiting List is arranged for thirty visits daily. It also gives a useful memoranda for physicians and surgeons upon a variety of subjects which are brought to notice in daily clinical work. It is gotten up in wallet form with handsome red seal binding, tucks, pocket, pencil and rubber. It is one of the most attractive and conviently arranged visiting lists we have ever seen. The *Medical News* will soon issue a "Physicians' Ledger" in which may be kept all the accounts of a large practice, either kept in Single Entry or Double Entry. This Ledger will contain 400 pages fine linen "ledger" paper, handsomely bound in half Russia with patent flexible back. These two books will be indispensable to every busy practitioner.

The Principles and Practice of Medicine. By Chas. Hilton Fagge, M. D., F. R. C. P., Examiner in Medicine in the University of London, etc. Edited by P. H. Pye-Smith, M. D., F. R. C. P. Physician to, and Lecturer on Medicine at Guy's Hospital, etc. Two

Volumes. Royal Octavo. About 1000 pages each. Published by P. Blakiston, Son & Co., 1012 Walnut Street, Philadelphia, 1886. For sale by Cushings & Bailey, Baltimore.

Our readers will recall the notice made some months back announcing the sudden death of Dr. Charles Hilton Fagge, one of the most distinguished of the younger physicians of London Dr. Fagge was cut down in the prime of life and in the midst of most laborious and faithful duties. He had for many years been intimately connected with Guy's Hospital, and had made laborious reseaches into its pathological and clinical records. He was a nephew of Hilton, the author of "Rest and Pain," and like him, had many of the best characteristics which go toward the making of a physician. He has been represented as the type of true medical greatness, being gifted with a quickness of perception, a genius for clinical facts and a patience in observation. The last twelve years of Dr. Fagge's valuable life were occupied in the preparation of the splendid work, now for the first time given to the profession. Dr. Fagge's life was cut down before the full completion of his labor, but the few chapters not written have been furnished by the editor, Dr. Pye-Smith and by Dr. Samuel Wilks, his old preceptor. The volume before us is the result of Dr. Fagge's entire labor. It shows on every page the patience and untiring industry of its author, his great natural ability as an original and independent observer and interpreter of clinical facts, and his practical acumen in presenting there facts in a concise, clear and forcible manner. It is probable that a more original and elaborate text-book on medicine, than the one now under consideration, has not appeared. The many strong and striking features of this work we have not the time or space at our command to bring out. We may briefly refer to the fact that its gifted author was a diligent reader of French and German periodicals, and, in addition to the wealth of clinical material placed at his command from the records of Guy's Hospital, he has used the material from these foreign languages to eminent advantage. The volume is published in the best style of the printer's art, upon excellent paper, and in clear bold type. We take pleasure in commending such a work to the consideration of our readers.

Miscellany.

Iodoform for Gout.—Iodoform, administered internally, appears to lessen the pain and frequency of attacks of gout. A grain is sufficient for a dose, taken two or three times daily.—*Med. World.*

Incontinence of Urine.—Prof. Eustace Smith recommends the following for incontinence of urine in children.

℞.	Tr. belladonnæ,	gtt. j.
	Potass. brom.	gr. x.
	Infus. digitalis,	ʒ ij.
	Aq. ad. - -	ʒ ss.

M. This to be given as a dose three times a day, to child four years of age.

Osgood's Cholagogue or Ague Cure:

℞. Sulph. quinine, 2 drachms.
Fluid ext. leptandra, 2 drachms.
Saturated tinct. stillingia, 4 oz.
Fluid ext. podophyllum, 3 drachms.
Oil of sassafras, 10 drops.
Oil of wintergreen, 10 drops.
New Orleans molassess sufficient to make 8 ounces.
M. Dose one to two teaspoonsful.
—*New Idea.*

Insanity Among Female Physicians. —*The New York Medical Journal*, says the "Lyon médical" makes the remarkable statement that statistics show the disastrous effects of medical study on the intellectual faculties of woman. In the year 1881, it appears from the census, there were twenty-five woman practicing medicine in England, and our contemporary thinks that the number has undoubtedly increased since that time. From 1880 to 1884, eight had been placed in lunatic asylums, and at the close of last year three were under treatment.

An Injection for Paralysis of the Bladder.—The "Union Médicale credits the following formula to Dumreicher:

Extract of nux vomica, 3 to 6 grains;
Distilled water 6 ounces.

One sixth of the whole is to be injected into the bladder every day, and retained for an hour. At the same time, electricity may be used with advantage, and micturition is to be regulated as much as possible being passed every four hours.—*N. Y. Med. Jl.*

Warner's Safe Cure.—According to *National Druggist*, consists of

Nitrate of potash, 320 grains.
Liverwort leaves, one ounce.
Alcohol, two ounces.
Water sufficient.
Glycerine, one and a half ounces.
Essence of wintergreen, 40 drops.

Infuse the liverwort in one pint of hot water, after two hours strain and filter, dissolve the nitrate of potash in the liquid, strain and filter, add the other ingredients, and add water sufficient to make one pint.

Medical Items.

We should like to see a national medical body, wisely regulated and animated by broad and unselfish purposes; but the American Medical Association does not now furnish the picture.—*Med. Record.*

Dr. Edward DeLoughery, an old and highly esteemed physician, died at his residence in this city, on November 18th. He was a member of the Medical and Chirurgical Faculty of Maryland.

Dr. Alonzo T. Keyt, a prominent and successful physician of Cincinnati, died on the 9th of November, in his 58th year. He is best known as the inventor of a remarkably ingenious cordio-smygmograph.

A free circulating library for the blind has recently been opened in New York City. There are over one thousand blind people in that city, hence a library of raised letter books will prove of great value to these people.

The *Medical Record* states that medical offices in New York city, with reception room privileges command a rental of from fifty to one hundred and fifty dollars per month, according to locality.

The Berlin Medical Society recently celebrated its twenty-fifth anniversary. In a speech made by Professor Virchow it was stated that Professor Eulenberg had given the Society 10,000 marks as a fund for securing a suitable building for its meetings.

The chair of Practice of Medicine in the Long Island College Hospital, made vacant by the recent death of Dr. Samuel G. Armor, must be filled by the best available man. All applications should be addressed to Dr. A. J. C. Skene of Brooklyn, N. Y.

Trephining the skull for epilepsy was first practiced in America by Prof. Dudley at Lexington, Ky. It was a revival of the old operation of La Motte in the United States. The *Transylvania Journal of Medicine* contains the particulars of five cases of this operation performed by him.—*Lous. Med. News.*

Dr. Charles Richet, in a cummunication to the Académé des Sciénces, describes the results ot his experiments with chloride of rubidium. Its physiological effects are the same as those of chloride of sodium, but its toxic properties are only half those of table-salt. Dr. Richet, therefore, recommends chloride of rubidium for chloride of sodium in therapeutics.

The *Medical News* states that the widow of Dr. William F. Jenks, has presented, as a memorial of her husband to the College of Physicians, of Philadelphia, in trust, five thousand dollars, the interest of which is to be triennially awarded for the best essay offered in competition upon some subject connected with obstetrics and gynecology. The prize is to be known as the William F. Jenks prize.

As for the American Medical Association, the whole profession has at one time wished it well, and hoped much from it. But what actual good is it doing? Has it helped a single educational reform, lessened quackery, amended, unified, or helped the enactment of medical laws? Decidly not. That it has done good in the past, in stimulating medical organization and promoting the solidarity of regular medicine, we gladly admit. It is because it has ceased this work and has broken and divided the profession that it meets opposition and criticism now.—*Med. Record.*

The State of Tennessee has recently established a new asylum for the insane at Lyon's View, near Knoxville, in East Tennessee. Dr. Michael Campbell is the Superintendent and Dr. C. C. Fite is the Assistant Superintendent. The State has also made an appropriation for another asylum in West Tennessee.

An Association to be known as the "American Anti-Vaccination Society" has been organized in New York city, in which Mr. Henry Bergh, the prince of fanatics, figures conspicuously.

The Academy of Medicine of Ireland has elected as Honorary Fellows the following well-known gentlemen: Sir William Jenner, Bart., M. D., as representing medicine; Mr. Jonathan Hutchinson, F. R. S., Surgery; Dr. T. A. Emmet, of New York, Gynæcology; Mr. John Simon, C. B., State Medicine; Prof. Ludwig, of Leipsic, Physiology; and Prof. von Recklinghausen, of Strassburg, Pathology. The compliment to our fellow countryman, Dr. Emmet, is well-bestowed, for no worker in this field has done more to advance its position than Dr. Emmet.

Professor Virchow in discussing the present states of the International Medical Congress, asks the question. "How did this delemma originate?" He answers, the question in this way. "In the fact that American Medical Association has set up a code of ethics, so called, and that with this code of professional ethics the admission to the Association is so broadly extended that entrance is free to all manner of dubious individuals. Hence has it resulted that, instead of eminence, mediocrity has come to the front, and that this Association, where the code is concerned, concerns itself more with forms than with principles."

Malignant Growths invade the surrounding tissues, and in general are to be distinguished by this peculiarity from tumors which displace the adjoining structures.—*Cancer*, by Willard Parker, p. 4.

There are three training schools for nurses in New York city, which are connected with the New York Charity and Bellevue Hospitals. The applicants for admission during the year 1884 were 216; and of these only twenty were accepted. The course of instruction at these schools is from eighteen months to two years. Applicants must be between 25 and 35 years of age, have a common-school education, be of good moral character, and in good health. Their salary is ten dollars for the first six months, thirteen for the second, and sixteen dollars for the rest of their term of service; boarding and lodging are free of charge.—*Cor. Louisville Med. News.*

The renowned Dr. John Huxham, who lived in the latter part of the seventeenth and greater part of the eighteenth centuries, was a great Latin scholar and a faithful student of the works of Hippocrates. He urged young physicians to read and re-read these works in the following language: "But, ye young novices in physic, approach nearer to the fountain head and drink freely, and you will from thence perceive how sagacious and diligent the Ancients were. A man will make a much better physician for so doing; for Hippocrates studied Nature with the greatest care and assiduity The Ancients gave the picture and naked truth of things, which is infinitely more beautiful than the affected daubings and flourishes of a modern luxuriant imagination."

Original Articles.

VERSION OR HIGH FORCEPS*.

BY G. W. MILTENBERGER M. D.,

Professor of Obstetrics in the University of Maryland.

A purely practical question, which has long divided Obstetricians, and upon which there does not as yet seem to be a universal agreement among them, and which should be, if possible, definitely settled, is as to the best course to pursue when artificial delivery is demanded in the interest of mother, or child, or both, when the head is still free above the upper strait and movable, or where delivery is urgent, when the vertex has partially entered the strait, but has not yet engaged, and readily recedes under pressure by the fingers, or as soon as we attempt to apply the forceps.

Of course we have here but the alternative; steadying the head from without by abdominal pressure and then applying the forceps, or version.

In the first place, we have to take into consideration the difficulty of readily and properly grasping the head, even when thus held, thus high, and while we know that it can be done and is done, we equally well know, that, at times, it is not by any means facile. In the second place, when thus seized and at this point, when the whole of the transit through the pelvic canal is to be affected by this *vis a fronte*, we equally well know the dangers to the maternal structures, with the best and most appropriate instruments, and here the Tarnier in some of its modifications, should be used, and with the best tactile skill and experience In the third place, we are equally well aware, that to avoid the second danger time is required, and the descent of the head must be gradual, while the safety of the child may also thus be endangered; while with version in skillful hands, we have the delivery of the child completely under our control, as soon as we have seized and brought down the foot or feet. If we look at the general statistics in relation to the child, as to the results from version, it is very true that we are met by a picture not at all re-assuring, but on the contrary laid down in colors so dark as to cause us to hesitate before resorting to it, whenever it can properly be avoided. Thus at the clinique de Paris (*Depaul*) in the years from 1852 to 1880, both included, there were 172 cases,the mortality to the mother being 13.95 per cent., children 50 per cent.; but a considerable number of them were brought into hospital, after various manœuvres had been previously tried, and mother and child thus seriously compromised. (*Charpentier.*)

Zweifel gives the mortality of internal podalic version at 8 per cent. of mothers and 58.9 per cent. of children.

Madame La Chapelle puts the infant mortality at 1 in 3.96.

Carus, Osiander, Kiwisch, Michaelis return it as 1 in 2; Ricker loses 1 mother in 10; Hueter 1 mother in 14; and Churchill in 542 versions, places the mortality of the infant 1 in 3 and mother 1 in 15. This is unquestionably a frightful record, but we must bear in mind the fearful accidents, which render the operation necessary in a great majority of the cases, including, besides trunk presentation, hemorrhage, eclampsia, rupture of the uterus, certain presentations of the face, prolapse of the cord, cases of monstrosity, dystocia caused by tumors, contracted pelvis, etc., while we all know personally and practically its almost absolute safety, when time and opportunity can be well chosen, as in those cases of which we speak, when the head is movable above the brim, and the uterus is not so contracted as to hold the head fixed at the strait. The chief dangers to the mother, are:–nervous shock, which may be entirely left out of consideration with the use of a stimulant and chloroform, which should always be employed, and which is as likely to occur with forceps; rupture of the uterus or other mechanical injury, but little to be feared, save when the waters have been long evacuated and the uterus strongly contracted upon the child, and not then unless undue force is employed, and here

*Read before the Gynecological and Obstetrical Society of Baltimore, November 10th, 1885.

they do not fall in this category; and septicæmia from the introduction of the hand. But in this case, I do not see that there is really any difference between the introduction of the hand and the introduction and application of the blades, and if there be some slight difference, the anti-septic cleansing would be as sufficient in the one, as in the other.

If we take merely general forceps cases, on the other hand, we find them not free from danger.

Poppel in 102 cases without complications, gives a mortality of 11 per cent. for children, and Spiegelberg, in his own clinic, where the forceps are applied only when stronly indicated, gives his mortality in children for 5 years, 17 per cent.

Siekel of 6.228 infants extracted by forceps, gives 1,069 lost, between 16 and 17 per cent. In 6,685 forceps cases, 184 mothers died, nearly 3 per cent.

Murphy's table of 248 forceps cases, gives a mortality of 20 mothers, and of 50 children.

Harper's table (forceps) gives us:

Collin's	fœtal mor.	1:26;	Maternal	1:329
Hardy	"	1:20;	"	1:334
Johnston	"	1:30;	"	1:502
Harper	"	1:47;	"	1:1490.

These included all cases.

We have no statistics of high forceps alone, which must be much worse.

Such is, it is true, in the majority of these reports, very widely different from our results in private practice; and in addition we are perfectly well aware of the unsatisfactory character of statistics in obstetrics. We know nothing of the special character of the cases, we are of course, ignorant of the details, we are not informed of the time or the mode of operation in the given case, nor most frequently of the methods or skill of the operator, while in many of them, the subjects have been brought into the hospital after having been submitted to various, and it may be, to crude and prolonged or repeated manipulations. But still there are the same sources of distrust and error in both these sets of cases, and in all probability the errors in one will offset those in the other, rendering them, at all events, approximately true for purposes of comparison.

I have, intentionally, merely mentioned in the one and the other operations, those dangers incidental to the manipulations themselves, and liable to follow in the hands of those best supplied and most skilled.

I have purposely omitted those, which the advocates of one or the other method may say, do not occur in their hands, and are but the result of want of cultivated skill on the part of the operator. These are for high forceps :—Injuries to maternal parts due:

1. To direct pressure of the widely separated blades, during traction.
2. To pressure of the fœtal head, which we are attempting to drag through the pelvis, it may be, in a faulty position.
3. To slipping of the blades.
4. To inclusion of some part of the maternal tissues in the grasp of the blades.

In version, besides those mentioned, metritis and peritonitis, very infrequent and usually preventible accidents. As to the child, we are all aware of the possible dangers in version, from forced extraction, if we at once follow the one with the other, and equally aware of the means of avoiding such dangers.

In high forceps we meet with abrasion or contusions of the face with facial paralysis, swelling and ecchymosis of eye, etc., more lasting injury to scalp or face resulting in sloughing or abscess, indentation or fracture of the cranial bones, lesions of brain substance or intracranial hemorrhage, due to compression of the head by the forceps or against the pelvic bones, or the above mentioned fracture of the skull, possible pressure upon the umbilical cord and consequent asphyxia of the child.

As to the difficulties of the operative procedures, they should not, it is true, be taken into consideration, if circumstances, demand one or the other, but as merely incidental, there is no comparision between them.

Version, in the cases mentioned, is simple and easy, while the high forceps, if the head is movable above the brim, demands and exacts the highest and most cultivated skill on the part of the accoucheur, and if applied skilfully, handled

judiciously and the object accomplished successfully and safely for mother and child, at once stamps his rank and position. Now let us examine the opinions of operators, and the weight of authority. One of the first, if not the first, to apply the forceps in this position was Smellie, as was perfectly natural after his great improvement of the instrument and the consequent extension of its field of usefulness.

He was followed in this by Solayres, Deleurye, Courtouly among the French, and Baudelocque somewhat later gave full rules for the operation, without however concealing the difficulties that underlay its performance.

Moreau says: "Smellie was the first to recommend the application of the forceps to the head when it was still above the superior strait. This operation is difficult and dangerous, therefore it appears to us, that the cases to which it is applicable, are very limited in number. We reduce them to two:

1st. When there is a moderate contraction of the pelvis; but the child being above, the forceps should never be applied if the antero-posterior diameter is not at least three inches and three-quarters in length.

2d. When the pelvis is well-formed *but version is impossible*, because the liquor amnii having been discharged for sometime, the uterus embraces closely all the parts of the fœtus."

Madame Le Chapelle, says (*Cazeaux*). "An application of the instrument upon a head which is still above the superior strait, is both a difficult and a dangerous operation. Difficult:

1st. Because its elevation renders the diagnosis of the position obscure, and often leaves us operating in the dark.

2d. From its mobility it escapes from the forceps, and not unfrequently it is merely held by the points or margins of the blades, so that as soon as any resistance is met with from the first tractive-efforts, it slips out just like a cherry-stone when squeezed between the fingers, and

3rd. Because, at this height it is impossible to apply the blades on the sides of the head, since the latter is usually found in an oblique or transverse position.

Dangerous, because the hold on the head being very imperfect,in consequence of the difficulties just enumerated, the instrument may slip; and should such slipping take place, while we are making strong traction on the handles, the edges of the forceps, acting like a cutting instrument, might seriously wound the cervix."

Cazeaux says: "If the head be but little or not at all engaged at the superior strait, version would be preferable, unless the pelvis was very narrow, or the womb so firmly contracted as to render the introduction of the hand unusually painful or even impossible."

With this Simpson agrees.

Hodge distinctly asserts: "The *fixation* of the head and its partial projection through the superior strait, seem to us essential pre-requisites for the operation of the forceps."

Chailly lays down the same rule.

Leishman says:* "But in some cases (in which we may assume the pelvis to be of normal dimensions) the operation of turning will generally be preferred."

Parry: "Many prefer forceps to version even when the head is movable, but the difficulties are so great that many prominent authorities practice version in preference to employing forceps under these circumstances."

Playfair concludes: "If the operation be attempted before the head has entered the pelvic brim, it must be fixed, as much as possible, by abdominal pressure."

R. Barnes, 1879: "In lingering labor, when the head is resting on the brim, the liquor amnii discharged, and it is known, either by exploring with the hand or by other means, that there is no disproportion, or only a slight degree of disproportion, even although the cervix is not fully dilated, the forceps will generally be better than its alternatives, *i. e.*, expectancy, ergot or turning."

Lusk insists: "So long, indeed, as the head is movable at the brim, and version is practicable, the latter operation furnishes the safer mode of delivery." 1885.

Charpentier sums up: "The majority of authors agree in preferring *version* to

*Leishman, p. 490. Edition, 1874.

forceps, in all cases, where this is possible."

Verrier says, 1884: "The forceps *may be applied* above the superior strait," and with this Pajot coincides.

Schrœder lays down the rule: "Whilst the head is still movable above the brim, version is easy, and this should always decidedly be preferred;" and he goes further and declares, under the head of contracted pelvis, that "a gentle attempt at turning is always harmless and often succeeds when the head is apparently impacted, thus affording the best chance for mother and child."

Naegele, 1872, says: "We (German) obstetricians discountenance the forceps in these cases altogether."

Zweifel says: "When only a small segment of the head can be felt in the pelvic brim, *i. e.*, when the entire head still remains above the small pelvis, the operation of high forceps is altogether out of the question (should not be considered), and this opinion fully accords with, and is but the reiteration of that of other experienced obstetricians." Here he advises version.

Zweifel lays great stress on the fact, that version and extraction are entirely separate and distinct operations, and do not necessarily go together, as antecedent or consequent, unless the circumstances of the case require it. This must be considered in estimating the dangers of version. "In the obstetric clinic we have often been able to demonstrate cases, where the fœtal heart-sounds, which immediately after version were very weak and slow, have after a while become stronger."

I have been induced to bring this subject before the Society from having had within a comparatively short time two cases illustrative of the points I have presented, not with a view of laying down the law or of determining the question by my dictum, but merely to open for discussion, a subject of so much practical interest.

Mrs. N.; multipara. In two previous labors forceps had been demanded. There was slight antero-posterior contraction, which, however, had previously permitted a natural delivery. After a somewhat prolonged labor, the mother's condition required relief, the head being but partially engaged in the superior strait. Forceps were applied, Hodge and Simpson, in succession, and although the instrument held and did not slip, the most powerful traction, which I thought justifiable, failed to engage it fully. Forceps were removed, hand introduced, head receded readily and without effort, version and extraction followed. Mother and child were both saved, and no difficulty during puerperium.

Mrs. S.; multipara. After a tedious labor, mother and child both, I thought, demanded prompt delivery; vertex presenting, but movable above the strait; pelvis normal; head large, as verified after birth. Placing her in position, I found upon attempting to use the forceps, even with abdominal pressure from above, that I had difficulty in applying them satisfactorily, and feared in the first place, lest they might slip, and in the second, that with the requisite delay for safety, the child would be lost. I withdrew the instrument, passed in the hand, turned and delivered promptly, and safely for both. Puerperium uninterruptedly good for mother and child.

A case which caused me much regret at the time and since, was that of Mrs. C., multipara, some years since, in which, after severe and exhausting labor, the head still above the brim, I applied in succession Hodge, Simpson and Tarnier, and securing a firm and unyielding hold with last, exerted my whole power, without being able to bring down or thoroughly engage the head. I then waited for an hour and a half for further natural efforts, when I succeeded with the forceps, but the child was still-born. I was convinced at the time, and am now, that if I had resorted to version previous to the use of the forceps, or directly after my first failure with them, I would have saved the child and have relieved the mother that much earlier. This caused me the more regret, as it was one of only four still-born children I have had the misfortune to meet in ten years. The other three were, one of presentation of the brow and two breach presentations in primipara, where the waters were evacuated early, and where, after dilata-

tion of the os, complete in one case, partial in the other, the most determined manual efforts were required for their extraction.

Society Reports.

BALTIMORE GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY.

FIRST REGULAR MEETING, HELD NOVEMBER 10, 1885.

Concluded from page 84.

Dr. George W. Miltenberger read a paper on

VERSION AND HIGH FORCEPS.*

Dr. P. C. Williams said it was very difficult to speak upon a paper that was so full and covered so much ground as that to which we had just had the pleasure of listening. It was also very embarrassing for him to feel compelled to differ from one whose ability and experience enabled him to speak with an authority that very few members of the Society could command. He said his own experience, though very limited as compared with that of Prof. Miltenberger, compelled him to differ with him in the choice of methods when the head was still unengaged in the superior strait of the pelvis. The statistics quoted seem very formidable, but most of them express the experience of practitioners prior to the general use of anæsthetics and of Tarniers' forceps, and we all understand the difference this would make in our choice of a method. But Dr. Miltenberger's statistics did not correspond with his (Dr. Williams) experience and that experience had taught him in most cases to prefer the forceps to version. After the membranes are ruptured version is rendered much more difficult in all the cases demanding interference and in such cases experience had taught him to prefer forceps. Again, the child may be of normal size and the pelvis abnormally narrow; or the pelvis normal and the child abnormally large. In either of these cases the Doctor would choose forceps rather than version, especially since the introduction of Tarniers' forceps, for the reason, that, to his mind, version does not change the relative proportion of either the child or the pelvis, whereas the forceps may and do more or less compress the head and thus diminish the disproportion. In those cases where the disproportion is considerable, version is certainly very difficult and if we fail to deliver we have greatly increased the difficulty of applying forceps or of performing craniotomy, if such a procedure should be demanded. Experience has shown him that axis traction, as applied by Tarnier's forceps, greatly facilitates the delivery.

Did time allow, he might give cases illustrating these points and showing that in his hands forceps are more easily managed than version. After all in many cases the choice must be decided by each man's own experience and by the facility with which he performs either method. One man has acquired facility in the use of forceps while another finds version more easy to perform. Either would find his judgment greatly influenced by his previous training and the facility with which he operated. He had acquired facility in the use of forceps and therefore, under ordinary circumstances, would be inclined, by habit, to resort to them, as the procedure which had hitherto proven successful in his hands. From the paper we had just heard read, we learned that Dr. Miltenberger's experience with version had been remarkably favorable and therefore he naturally inclined to that method of delivery.

Dr. Williams also said there were various other points to which he would like to call attention, but that he felt he had already spoken longer than he ought.

Dr. Miltenberger, in reply to Dr. Williams, said that his paper dealt with cases of normal pelvis and heads, or those in which the heads were but slightly enlarged. When the head presented by the vertex, the base of the triangle presented, while after version the bi-mastoid

*See page 97.

or the shortest diameter of the head and the child could more easily be stripped through, and that since first proposed by Simpson, this had been almost universally recognized.

Dr. Thomas Opie said he considered that the introduction of axis-traction forceps had created a new era in obstetric practice, and had changed the relations between version and the forceps. There were certain cases in which version was to be preferred to forceps viz: in occipito-posterior positions, in transverse positions, in posterior positions of the face whether at the superior strait or in the excavation, in placenta-prævia and in antero-posterior contraction of the pelvis to 3¼ inches. In other cases he would give the preference to traction-rod forceps. He agreed with Dr. Lusk's view, that the old Tarnier blades are best adapted to securing the head above the brim. He ordinarily uses the Taylor narrow blade forceps, which will go through an os measuring one and a half inches in diameter, to dilate with in cases where the Tarnier blades cannot be introduced. The method of turning by bi-manual effort, the hand in the vagina but only two fingers inserted into the uterus, as suggested by Braxton Hicks, is worthy of imitation. Of course his choice of methods was controlled by the peculiarities of the individual case, but taking all in all he used forceps in the greater number of cases.

Dr. W. P. Chunn in reference to the subject, mentioned a case which he had recently seen in consultation, in which the patient had been in labor for 3 days, and had lost a great deal of blood on account of a placenta-marginalis. The head was high up and the uterus soft and flabby. In this case he delivered with forceps because he thought it could be done more quickly than by version.

Dr. T. A. Ashby remarked that there were two strong arguments in support of the operation of version in these special conditions referred to in Professor Miltenberger's excellent paper. The first was to be found in the fact that the operation of version had been so simplified by the method of Baxton Hicks, that it was no longer the formidable procedure, as in past days. Version may be accomplished with comparative ease by the combined method before the escape of the amniotic fluid. After this, its employment is attended with greater difficulties; still the writer of the paper had reported several cases where version had been successfully accomplished within a uterus emptied of its liquid contents.

The second argument was based upon a well known doctrine, advocated by some of the best obstetric authorities, to wit; that when version failed the forceps could still be resorted to, whereas, after an attempt to deliver with forceps and a failure, the operation of version would be undertaken under most unpromising conditions. He thought that, in those cases when the head was freely movable above the brim, version was an easier and more preferable method of delivery than with the forceps.

Dr. H. P. C. Wilson said, that, in the class of cases mentioned in Dr. Miltenberger's paper, he would turn every time. He had failed repeatedly with forceps and succeded afterwards by turning and he had lost children by depending on the forceps, that he felt certain he might have saved by resorting to version earlier.

Dr. W. T. Howard said whether version or the forceps is to be preferred in the interest of the mother, or the child, or both, when the head is free and movable above the superior strait or when the vertex has partially entered, but has not become engaged in the strait, is a very complex problem. Its solution, as it seemed to him, depended upon such a variety of circumstances and conditions that no hard and fast line can be drawn between the two; and that each case, therefore, must, in practice, be decided for itself. All things considered, Dr. Miltenberger thinks that, in such cases, there is no comparison between the two, and that while version is simple and easy, the successful use of the forceps demands the exercise of the highest skill. Still, he admits, and indeed, proves by a long array of statistics gathered from the writings of a large number of eminent obstetricians in different countries, that version is attended by a mortality to the child so frightful, that we should hesitate

to resort to it whenever it can be properly avoided. And, on the other hand, the statistics adduced prove that the mortality to the mother by version is much less. Thus, to cite only a few of the cases Dr. Miltenberger has brought before us: while Depaul, in the Paris Clinique, found that in 172 cases the mortality to the child by version was 50 per cent., to the mother it was only 13. 95 per cent. Zweifel gives by version a mortality of 58.9 per cent. for the child, and only 8 per cent. for the mother. And Churchill, in 542 versions, places the infant mortality at 1 in 3, and to the mother at 1 in 15. It is clear, then, that, according to these statistics, version is an operation greatly to be prefered in the interest of the mother, and obviously to be shunned in the interest of the *child*, if the forceps gives the latter a better chance for life. What, then, does the *forceps* present in the interest of the child? In 102 forceps cases, Poppel gives a mortality of 11 per cent. for the child, and Spiegelberg in his clinic during five years an infant mortality of 17 per cent. It seems to be equally clear that the forceps gives the child a better chance for life than version. These statistics, however, are not derived from high forceps operations, of which Dr. Miltenberger says there are none, but he infers that they must be much worse. That however, depends upon the kind of forceps used and the skill of the operator.

But what chance for life does the forceps offer the *mother*? In 6,685 forceps cases Sickel states that 184 mothers died —nearly 3 per cent. only. And I may add that Dr. George Johnson, of the Dublin Lying-in Hospital, applied the forceps in 113 cases before the head had passed out of the os uteri, not only to save the life of the child, but also to prevent much danger to, if not the death of the mother from the effects of long-continued pressure on the soft parts, and without a fatal result to either mother or child. Of course, this demanded exceptional skill; but it shows what a conservative instrument the forceps is both for mother and child, when in the hands of men of large experience and the highest skill. And it proved to Dr. H.'s mind that in the hands of such operators the forceps offers a better chance for life both for mother and child, in many cases at all events, than does version, and especially for the latter. Dr. H. admits that when the head is free above the brim, the cervix easily dilatable, and the membranes unrupted, version by a skilled hand may be readily accomplished, and that the danger to the mother may not be great. But the danger to the child must be greater than that from the forceps in equally skilful hands. It is often said that when, in version, the feet are drawn through the os externum, the case does not involve greater risk to the child than in an original feet presentation. If this be admitted, podalic version involves greater risk to the mother, as in head-last labors demanding rapid passage through the os (always badly-dilated in primiparæ in manual delivery) of an uncompressed head, the cervix is prone to be lacerated; while on the other hand, fenestrated forceps with small blades, under chloroform, may be often so used as actually to prevent cervical laceration. With one or two fingers of the left hand, carefully and slowly draw the anterior lip forward toward the vulva, or press the cervix over the head, while with the right hand, traction is intermittently and judiciously made in the line of the pelvic axis. But the infantile mortality in all pelvic presentations, whether natural or artificially made, is universally admitted to be much greater than in head presentations. In the former the risk to the child is so great as to be estimated by able obstetricians at 1 in 3. Dr. H. well remembered how vividly the late Professor C. D. Meigs used to impress upon the Class at the Jefferson Medical College the importance, in such cases, of having the forceps at hand ready for use, by relating a case, which is recorded in his work on *Obstetrics*, in which the child cried within the vaginia, while his forceps were sent for. The head was speedily withdrawn when he received the instrument, but too late to resuscitate the child. And his successor, the late Professor Ellerslie Wallace, always emphasised the importance of having the forceps at hand in such cases, and, indeed

in every case of labor, and published a paper to enforce that view.*

In the successful use of forceps, much depends not only on the skill of the operator, but, also, on the kind of instrument employed. There cannot be a doubt but that in delivering at or above the pelvic brim, or the upper two inches of the pelvic cavity, Tarnier's action-traction forceps possesses great advantages above all others. It has been many times demonstrated that an accurate adjustment of this forceps in the axis of the brim has accomplished delivery of a living fœtus when previously craniotomy or a dead fœtus were the only alternative. (Here Dr. Howard exhibited a variety of forceps.)

In practice, in our days, the forceps or turning are usually rivals for choice with men equally skilled in both, when the conjugate of the brim of the pelvis varies from 3¼ to 3½ inches. The *pelvis equabiliter justo minor*, or uniformly contracted pelvis, calls for the forceps. Whether we can deliver or not depends greatly upon the position of the vertex. When the vertex is well flexed, the posterior fontanelle low in the line of the axis of the pelvis, while the anterior fontanelle is high up or inaccessible, the forceps may be used successfully. But when the anterior fontanelle is on a level with, or depressed below, the posterior, and the sagittal suture traverses the transverse diameter of the brim, the pelvis is almost sure to be flattened, and early version gives both mother and child the best chance for life.

There are many cases in which version at the brim, or below it, are far from being simple and easy. When the waters have been long discharged, and the uterus lashed into fury by long and violent efforts to expel the fœtus, and strongly contracted in spite of profound anæsthesia, version ranks among the most difficult obstetrical operations. Under such circumstances Dr. H. has seen three physicians, one after another, have their hands rendered temporarily paralyzed and powerless, and when delivery was finally accomplished, the poor woman died. Dr. H. has also seen able obstetricians in such cases, fail to deliver at all. In a case of *placenta prævia*, and the hemorrhage copious and alarming, Dr. H. would not hesitate to turn at once, as soon as the hand could readily enter the uterus. But if dilatation could not be readily effected enough to permit the passage of the hand, Dr. H. would quickly apply the forceps. In cases of violent eclampsia, Dr. H. much prefers the forceps, especially in primiparæ, and have often succeeded in such cases in saving the lives of both mother and child by introduction of the forceps into the uterus. In such cases, it is easy to apply forceps with narrow blades, as Sir James Y. Simpson's forceps such as he used, when it is impossible to apply forceps with wider blades. And Tarnier's last model is preferable to those he formerly used, because in oblique applications the convexity of the old perineal curves comes into contact with one of the ischio-pubic rami and causes a deviation of the handle of the instrument, the action of which then becomes defective, and tractions made upon the forceps are not directed according to the median plane of the body.

Dr. Miltenberger, in conclusion, said that in private practice he had never lost a child by version. That the statistics he had read were made from hospital cases. He still maintained that a child could not be delivered by forceps more quickly than by version and at the same time with equal safety.

*The American Journal Medical Sciences, July, 1870.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD NOV. 6, 1885.

The meeting was called to order by Dr. Keirle in the Chair.

Dr. R. Winslow read a paper on

GANGRENE OF SCROTUM.†

Dr. W.B Platt did not think the affection due to extension of the inflammation from the point of incision, but that it was rather an atrophic process due to in-

†See Md. Med. Jour., page 57.

terference with the trophic nerves going to the part.

Dr. R. W. Johnson exhibited a patient who had sustained a fracture of the coracoid process of the scapula.

Drs. Branham and Platt confirmed the diagnosis by being able to feel the callous deposit at point of fracture.

Dr. Platt related a case of abdominal abscess, which simulated intussusception. This man afterward passed purulent urine.

Dr. W. J. Jones read a paper on

TUBERCULOSIS OF THE UTERUS.

The trouble occurred in a prostitute with well marked pulmonary trouble.

The special condition to which he wished to call attention was that found in the pelvic viscera.

On pulling up the omentum and mass of small intestines the pelvic peritoneum was found to be thickened and covered with tubercles.

That portion of the peritoneum which was reflected over the bladder and uterus had became adherent to that covering the rectum, so that in this way the space known as Douglas' cul-de-sac was converted into a cyst, upon whose roof rested the small intestines. This cyst was found to contain about 12 ounces of thick purulent fluid.

In the rectum just above the anus was a circular ulcer with indurated edges and covered by a necrotic mass.

The loss of substance occasioned by this ulcerative process was one-half inch in diameter and extended through into the vagina. The mucous membrane around the vaginal end of this fistulous opening was ulcerated and covered by a diphtheritic membrane. Microscopic examination of the caseous masses on the uterus and of the ulcers in the rectum revealed the presence of tubercle bacilli in large numbers.

Unfortunately no effort was made to detect these organisms in the ulcers of the vagina, nor along the fistulous tract, although histological examinations of both were made and showed the necrotic material to be the result of breaking down of mucous and submucous tissue.

Dr. Jones made a point of the fact that in these cases of pelvic tuberculosis the full stress of the pathological process, as well as its first appearance, was always found in the recto-vaginal cul-de-sac. He takes this as one of the factors in proving the non-soluble nature of the tubercle virus, for it is into this space that it, as well as any other foreign particle, will be found to have gravitated. He also called attention to the error in diagnosis that might have arisen from the presence of the cyst-like formation filled with pus. It could have been mistaken for an ovarian cyst or a pelvic abscess.

In a former paper on this subject the writer gave as his opinion that in these cases infection of the uterus usually occurred as a result of transference of the virus from the peritoneal cavity along the Fallopian tubes, as they were usually found to be affected; but in this instance such was not the case. He thought it probable that *here*, in view of the fact that bacilli were found in the rectal ulcers and that there existed a recto-vaginal fistula, that the virus might have passed along this tract into the vagina and thence to the uterus. In this case the occupation of the patient certainly favored such a means of infection of the uterus.

Dr. H. Harlan showed a specimen of aneurism of the renal artery.

Dr. W. P. Chunn related two cases of

AMENORRHŒA.

The first, æt. 23, had no uterus.

The second, æt. 25, married, and had never menstruated. He asked the experience of those members of the Society who had treated such cases.

Dr. B. B. Browne spoke of his success in treating cases of defective developement by the use of electricity. He referred to his paper on this subject read before the American Medical Association in 1884.

Dr. A. F Erich did not think it of any material difference whether a woman menstruated or not so long as she had no consequent pain.

Dr. R. Winslow showed a specimen from a case of

SARCOMA OF TIBIA.

Dr. Keirle thought it unsafe to oper-

ate in the continuity of a bone so affected.

SUPERNUMERARY LOBE IN RIGHT LUNG; ABNORMAL SITUATION OF RIGHT KIDNEY.

Dr. W. T. Councilman presented two specimens, one of which showed a supernumary lobe in the right lung. The extra lobe was formed by a re-duplication of the pleura which divided the apex of the lung. The azygos vein ran at the bottom of the fissure enclosed by the pleura. This is a very rare malformation of the lung, and one for whose formation no explanation can be given.

The specimen was taken from a man æt. 60, who died of croupous pneumonia.

The other specimen, also from a man, showed an abnormal situation of the right kidney. The kidney was placed inside the pelvis, at the sacro-iliac synchondrosis. The vessels, three in number, were derived from the aorta just above its bifurcation. The supra-renal capsule on the right side had the usual situation. The left kidney is more often found low down in the pelvis than the right. In examinations of the pelvis there is always a possibility of a kidney in this situation being taken for a new growth.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD NOV. 12, 1885.

The President, JAS. C. WILSON, M. D., in the Chair.

Dr. Fussell presented

SPECIMENS FROM A CASE OF MASTOID DISEASE.

The patient was a male, æt. 25 years. Never had scarlet fever. Since vaccination at the age of 5 years, has had occasional attacks of suppuration of the middle ear. General health was good. Was first seen by Dr. Fussell, July 14; for several weeks he had had earache, with one slight chill. When seen hearing was very poor, membrana tympani opaque, swelling and redness over left mastoid process and temperature elevated. His general condition grew worse, and an incision made over the mastoid process, but it failed to find pus. On extending this incision a few days afterward, pus flowed freely, and he was much relieved. He afterward grew worse, fell into a typhoid condition and died July 24. Before death, blood oozed freely from the cutaneous surface. At the autopsy, the mastoid cells were found filled with pus; in the inner half of the process was a large irregular cavity filled with a pultaceous mass of necrosed bone, this communicated with the middle ear. The walls of the lateral sinus were thickened, easily detached from the bone, and the seat of a purulent inflammation. The sinus contained no thrombus. The meninges over this spot were discolored, though not inflammed, but there was a patch of inflammation over the anterior edge of the left lobe of the cerebellum. Brain substance was normal. Remaining organs were not remarkable, except the right lung, which contained in its apex two small abscesses. From the condition of the sinus, the reporter thought there had been an actual admixture of pus with the blood.

Dr. John H. Packard presented

AN ANOMALOUS LUNG.

It was taken from the body of a negro who died of Bright's disease. From the inferior surface of the lower lobe of the right lung springs a tongue-shaped process of pigmented, crepitant lung tissue two and one-half inches long and two inches wide at its base, resting upon the diaphragm, its upper surface being in opposition with the under surface of the lower lobe. Dr. Packard had recently seen in the body of another negro a similar anomaly, except that the process was smaller and situated more anteriorly.

Dr. J. H. Musser presented a

CYSTIC KIDNEY.

It was the right kidney, and was taken trom the body of a man, æt. 72 years, who died of apoplexy. The kidney was cirrhotic and contained two cysts, the larger occupying the upper one-fourth of the organ. Its walls were firm, and it contained clear fluid in which floated cheesy masses, which the reporter

thought were degenerated pus. When first seen, the patient was passing small quantities of bloody, highly albuminous urine, and complained of pain in the right renal region. These symptoms were apparently due to an acute process grafted upon the chronic lesion. The blood and most of the albumen disappeared, but the pain persisted. Was this pain due to the cyst?

Dr. Musser presented also a

CARCINOMA MAMMÆ

removed from the body of a woman, æt. 75 years. The breast had been injuredeight years ago, and three years afterwards the tumor noticed. There was never any pain in the tumor. The lymphatic glands of the axilla were involved. In addition there was a large lipoma of the back of the arm. She had frequent attacks of severe pain in the tibia and left parietal bone, apparently due to periostitis, and not to any secondary growth. There was no syphilitic history.

Dr. Musser also presented

SPECIMENS FROM A CASE OF DIABETES MELLITUS.

The patient was a female, æt. 43 years. Had a vesico-vaginal fistula for fourteen years. Diabetes had persisted, without apparent cause, two months. Patient was unusually fat, and had lost no weight. She died of coma. Temperature in the abdominal cavity three hours after death was 107.8° F. Liver large and fatty; gall bladder contained thirty stones. Kidneys fatty. Pancreas normal. Blood had a most marked lactescent appearance, and after standing twelve hours globules of fat collected on its surface. Lacteals in the mesentery engorged with chyle. Microscopic examination of lung showed no fat emboli. In the urinary bladder was a large phosphatic calculus. Dr. Osler thought the peculiar condition of the blood was what we should find normally in a person dying during digestion, and called attention to the fact that very frequently in diabetics there is the engorgement of the lacteals.

Dr. Musser also presented a

FŒTUS PAPYRACEUS.

The mother was delivered in the morning of a mature living child, and in the evening of this fœtus. It is apparently of the fifth month of pregnancy, and with the exception of shriveling and paling of the skin, is quite normal. The cord is thin and soft, its length unknown. The placenta is thin, flat, compact, and whitish-yellow, apparently having undergone complete fatty degeneration.

Dr. John B. Roberts presented a

SMALL TUMOR, THE SIZE OF A HICKORY NUT, REMOVED FROM THE BACK OF THE WRIST OF A YOUNG MAN.

It had the clinical appearance of an ordinary ganglion, but attempted evacuation showed to be solid. It was then enucleated and found to have been developed within the theca of the tendon going to the middle finger, and probably between its fibres. The great rarity of solid tumors in this locality was mentioned.

Dr. Wm. Osler asked if the patient had a rheumatic history, although this specimen was rather large for a subcutaneous nodule occurring in rheumatism.

Dr. Roberts knew nothing of the history.

Dr. C. B. Nancrede presented *Fluid from an Encysted Hydrocele*, which fluid contained large numbers of dead spermatozoids.

Dr. W. E. Hughes presented a

PRIMARY CARCINOMA OF THE LIVER.

Female, æt. 58 years. A daughter died of cancer of the uterus. She had been in good health till 18 months ago, when flesh and strength began to fail. With this there were occasional attacks, lasting about a week, of headache and sick stomach, followed by diarrhœa. There was pretty constant lancinating pain in the hepatic region. Five months ago she had an attack of jaundice (her only attack), lasting two weeks, and at this time a tumor was detected in

the liver. At the autopsy the liver was found much enlarged, and scattered through its substance were firm cancerous nodules varying in size from an orange to a pin head. In addition to these there were several cysts, one in the left lobe two inches in diameter, filled with clear fluid. The liver substance between the cancerous nodules was normal. The gall-bladder was full of healthy bile and the ducts patulous. There were no enlarged glands in the tissue of the liver, but the retro-peritoneal and mediastinal glands were increased somewhat in size, and the seats of secondary deposits; with these exceptions there was no growth outside the liver. The intestines were crowded into the left side of the abdomen by the enlarged liver. The stomach was very small, only one inch in diameter at its fundus. There was an intussusception, three inches in length, at the ileo-cæcal valve, which, on being reduced, which was effected with some difficulty, showed the opposed surfaces of peritoneum covered with lymph.

Dr. H. F. Formad presented specimens and read a paper on

AN ANALYSIS OF 250 AUTOPSIES ON DRUNKARDS, ILLUSTRATING THE MOST PROMINENT ANATOMICAL LESIONS OF CHRONIC ALCOHOLISM.

He considered the most conspicuous lesions to be cyanotic induration of the kidneys, fatty infiltration of the liver, and mammilated stomach. His cases had been those in which there had a been a history of a long-continued series of debauches, the subjects often dying in one of these debauches, and did not include moderate drinkers or those who perished after imbibition of an enormous quantity of alcohol without any previous chronic causes. He thought that the exposure, irregularities of diet, etc., incident to a state of drunkeness, had much, probably more than the alcohol itself, to do with the production of the lesions, but it was not at all possible to separate one from the other. He gave a long list of chronic alcoholism, among which the cirrhotic liver, with contraction, held a prominent place. He had himself at one time considered cirrhosis a very frequent, if not almost necessary, concomitant of long-continued excessive use of alcohol, and had even testified in court that a certain person was not likely to have been a hard drinker because at the autopsy no cirrhosis of the liver was found. He had thought, too, that the connection between the two was so close that it was impossible to have a case of cirrhosis without a previous history of alcoholism, as is held by various authors. Therefore, it was suprising to him to meet in his 250 autopsies with only six cases of cirrhosis of the liver with contraction. In 220 cases the liver was considerably or even very much enlarged, the enlargement in most cases proving to be due to a fatty infiltration. Cyanotic induration of the kidney, and chronic gastritis with mammillation of the stomach, were found in nearly every case. This cyanotic induration is peculiar, and differs from the cyanotic induration due to heart disease. At a future time he will give a detailed account of the above lesions, and a more extensive analysis of the cases.

Dr. James Tyson could not speak from a systematic observation of a large number of autopsies in the cases of confirmed drinkers, but he remembered distinctly being surprised, in several cases, by the absence of cirrhosis where he confidently expected to find it.

Dr. Wilson said that Anstie, in the article on alcoholism in "Reynold's System of Medicine," had called attention to the comparative infrequency of contracted liver in confirmed drinkers. This observer, in an extensive out-patient practice in London, had seen large numbers of cases of alcoholism, but very few among them present the physical signs of cirrhotic (contracted) liver. The experience of the staff at Blockley Hospital confirms this view. There many of the patients are soaked with alcohol, but even among those whose death is dilrectly or indirectly due to alcoholic excess, fatty liver is much more common than contracted liver.

Dr. Osler thought the experience of pathologists and morbid anatomists

with histories of patients not of the most satisfactory character, he often having had cases to dissect where he knew very little of the history. Before saying these cases were chronic alcoholics Dr. Formad should present more specific statements about them. His own experience with livers, in a large number of autopsies on cases of chronic alcoholism, had led him to divide them into four classes: 1. Those in which the condition of the liver is pretty satisfactory; some of these cases may take alcohol for many years and yet the liver pass muster. 2. Fatty cirrhotic livers; the cirrhosis may not, perhaps, be distinct to the naked eye but plainly shown by the microscope; this is the largest class. 3. Hobnail livers; these he would say were much more common than in Dr. Formad's series. 4. Hypertrophic cirrhotic livers. The difference between his observations and those of Dr. Formad might possibly be accounted for by a difference in the form of alcoholic beverage taken. He had not observed the special form of kidney described by Dr. Formad. In reply to a question, he said in order of frequency he would place them fatty cirrhotic, hobnail, hypertrophic cirrhotic, apparently normal

Dr. S. Solis-Cohen said that there were certain theoretical considerations which suggested themselves in this connection. The text-books teach that the lesions of alcohol are of two kinds, sclerosis and steatoris. It is known that in some organs the fibrous change precedes the fatty one. The latter is the higher grade of degeneration. The subjects of Dr. Formad's autopsies were confirmed whisky-soakers, in whom one would expect to find more intensity of degeneration than in those whose use of alcohol, though persistent and excessive, was not so outrageous. Another point which had not been alluded to was the fact that some lesions might result from a local action of the poison upon the tissues, while others might be due to its systemic action. No study of the subject could be complete in which these points were overlooked.

Dr. B. A. Randall suggested that the point touched upon by Dr. Osler—the character of alcoholic beverage—might be very important. In Vienna, among beer drinkers, he had found the fatty liver much more common than the cirrhotic, while in England, where much gin is drunk, and he should suppose in Scandinavian countries, where they drink altogether strong spirits, the cirrhotic liver is doubtless comparatively frequent.

Dr. Musser had recently had to go over the records of the Pathological Society, especially in liver diseases, and had found the total experience of different observers the same as Dr. Formad's and also in those cases cirrhosis was caused not so much by heavy drinking as persistent drinking of spirits on an empty stomach.

Dr. Formad presented the

SAC OF AN EXTRA-UTERINE PREGNANCY.

The woman from whom this was removed had not suspected that she was pregnant. She was in perfect health until twelve hours before death, when she was suddenly seized with excruciating pain in the left groin, rapidly followed by collapse. On opening the abdomen it was found to contain at least a gallon of partly clotted blood. About the middle of the left Fallopian tube was the sac with a rent in its posterior wall. This sac was one inch in diameter and contained clotted blood and placental tissue. The uterus was twice its normal size. The fœtus was not found.

Dr. Formad also presented

AN ANEURISM OF THE ASCENDING AORTA RUPTURING INTO THE PERICARDIUM.

The patient was a laboring man and had considered himself in perfect health. He died very suddenly. The aneurism, half an inch in diameter, was situated just above the posterior aortic leaflet and had broken through the wall of the aorta at the point where it touches the descending cava. The cavity of the pericardium was fully distended with clotted blood.

Correspondence.

ABNORMAL MOBILITY OF THE TONGUE WITH ABILITY TO PROJECT INTO THE NASO-PHARYNX.

Editor Maryland Medical Journal.

Dear Sir:—In the November 28th number of the Maryland Medical Journal there is an extract from the *Medical Record* in which the above condition is reported by Dr. Jurist, of Philadelphia, who states that he was only able to discover three similar cases on record. The condition is certainly rare, and as I have met with one instance of it, I will add it to the number recorded.

Four or five years ago a medical student, now a physician, in this city, came under my care for a pharyngo-laryngitis, and on one occasion, while under treatment, he asked me if I had even seen a case where the tongue could be passed behind the palate. On telling him that I had not, he at once rotated the tip of the tongue backwards until he passed it behind the velum and up into the naso-pharynx. The appearance presented was very singular, and showing him to a medical friend, I asked what he thought the throat was. First he said tonsillitis; then, no it is a tumor of the naso-pharynx, but added almost immediately: where is his tongue?

Since the first exhibition of this remarkable mobility of the tongue the gentleman has on a number of occasions repeated it for myself and others. He says that he can distinctly feel the orifices of the Eustachian tubes, and can, by placing powders on the tip of the tongue, make applications to the posterior nares.

In this case the tongue was not abnormal in length and the frænum linguæ had never been clipped, though it was somewhat longer than usual.

H. Clinton McSherry, M. D.
189 N. Howard St.

A New Method of Cultivating the Bacillus Tuberculosis.—The Paris Correspondent to the *British Medical Jour.* writes: At a recent meeting of the Paris Biological Society, Professor Nocard, of Alfort stated that he had succeeded in cultivating the bacillus tuberculosis. On pursuing Koch's method, he arrived at negative results. He therefore modified the cultivation medium, by adding 1 per cent. of peptone to horse serum, 0.25 of sugar candy to a hundred parts of serum, and the same proportion of sodium chloride. These additions were made before gelatinisation was effected. The first three cultivations were made according to this method; the fourth was effected in pure serum of horse's blood, but the process was slower. According to M. Nocard, all domesticated birds are liable to tuberculosis; the bacilus found in them is identical with that of tuberculous mammals. In 1884, Johne (*Zeitschrift fur Microscopie und Fleischhand*) published some facts concerning a poultry-yard, which was infected with tuberculosis on the arrival of a phthisical person, whose sputa were poured on to the dung-heap in the poultry-yard. M. Nocard has published, in the *Recueil de Médecine Veterinaire*, three instances similar to that described by Herr Johne. Careful investigation demonstated that the birds succumbed from tuberculosis, after tuberculous sputa were mixed with their food. M. Nocard's data furnish proof that tuberculosis can be communicated to birds by animals. At Nevers, there is a tripe-shop attached to the slaughter-house. The proprietor of the shop has a small poultry-yard; most of the birds in it die from tuberculosis. They are fed on diseased parts of the animals which are unfit for sale; especially lungs, liver, spleen, and tuberculous glands. By inoculating with tuberculous matter from animals, or mixing it with the food, M. Nocard has killed four fowls, six pigeons, and a turkey. These all died in a space varying from six weeks to four months. In three instances they were fed on chopped-up lungs and tuberculous glands removed from a horse and two cows, all of which were phthisical. M. Vignal, at the meeting of the Paris Biological Society, pointed out that addition of sugar, sodium chloride, and peptone to serum, indicated a completely new medium of cultivation.

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BALTIMORE, DECEMBER 5, 1885.

Editorial.

STROPHANTHUS (HISPIDUS) AS A SUBSTITUTE FOR DIGITALIS.—It has now been about one hundred years since digitalis was first brought into notice as a therapeutic agent. Since its first introduction its physiological and its therapeutic action has received a large share of professional study. At first it was used to a limited extent as a cathartic; next it was recognized as a diuretic; and, subsequently, it was believed to be an agent which so influenced the circulation as to exert a sedative action on the heart. Owing to experimental investigation of its pharmacology its applications in disease have acquired a definiteness and extension, which render it one of the most valuable of therapeutic agents. The action of digitalis having been determined it was subsequently found that a similar action is produced by other substances. These substances have been classed under a special designation as the digitalis-group. Their action has been shown to depend on certain chemical bodies or principles which are present in them. In regard to the pharmacology of these substances, the most important action they exert is upon the circulation. They all increase the action of the heart, and they do so by increasing the strength of its contractions, and particularly the contractions of its ventricles. They all act upon the muscular fibres of the heart and are, therefore, muscle-poisons, when given in sufficient quantity. Their action upon the circulation is followed by various secondary effects. The first of these is an increase in blood-tension; another secondary action is the production of diuresis, and a third action is a reduction of temperature. The explanation of this last action is probably to be found in the more general distribution of the blood that is produced throughout the body, resulting in a larger quantity being distributed to the surface.

Increase in the strength of the heart's contraction and increase of arterial blood-tension constitute the pharmacological effects which are the main explanations of the therapeutical benefits obtained by the employment of these substances.

Digitalis has been employed as the most efficient of this group, and its action is best known. It is, however, recognized that several inconveniences accompany its therapeutical application. This fact has led to the employment of substitutes, but, whilst many have been tried, none have possessed the desired action. It has been argued that if a substance could be obtained which exerts a more powerful action upon the heart, and at the same time produces fewer secondary actions, experience would prove it to be a most valuable substitute for digitalis. This anticipation seems about to be realized in the drug which is named at the head of this article. Strophanthus has been studied most carefully for the past fifteen years by Dr. Thomas R. Fraser, of Edinburgh. The plant was first brought under Dr. Fraser's notice in connection with its employment in Africa as an arrow-poison. As far back as 1870 Dr. Fraser published some of the results of an examination of its chemical composition and pharmacological action in a preliminary communication in the *Proceedings of the Royal Society of Edinburgh*, and the *Journal of Anatomy and Physiology*. The difficulty of obtaining a supply of this drug, and other unavoidable circumstances, interrupted Dr. Fraser in his in-

vestigations, and especially the application of this substance to the treatment of disease,

In an article of uncommon merit, Dr. Fraser communicates the results of his recent investigation of strophanthus to the section of Pharmacology and Therapeutics at the Cardiff meeting of the British Medical Association. The article appears in print for the first time in the *British Medical Journal*, of November 14th. Whilst the conclusions reached by Dr. Fraser, with respect to strophanthus, are not altogether decisive and conclusive, his investigations seem to us to have a peculiar value. We will attempt in a brief way to give the main facts in regard to this new drug. The plant strophanthus belongs to the natural order of the *apocynaceæ*, and it is widely distributed throughout equatorial Africa. It produces a follicle from nine to twelve inches in length, within which are contained from one to two hundred oval seeds. The seeds are very active, and, when coarsely ground and formed into a paste, they constitute the poison with which arrows are smeared. The active principle of the seed is a crystalline body termed strophanthin. This active principle is also present in the leaves and bark of the plant, but in smaller quantity than in the seeds. The pharmacological action of strophanthus is described by Dr. Frazer as a muscle-poison. However introduced into the body, it increases the contractile power of all striped muscles and renders their contraction more complete and prolonged. In lethal doses it destroys besides the capacity of the muscle to assume the normal state of partial flaccidity, and causes the rigidity of contraction to become permanent, and to pass into the rigor of death. The heart is early and powerfully affected. Its systole is increased and its contractions are slowed by small doses; it is paralysed in a condition of rigid systolic contraction by large doses. This action upon the heart is accompanied by a rise in blood-pressure, which appears to be directly produced by it, and, in certain conditions, by an increased secretion of urine, and a reduction of temperature. The similarity in the action of strophanthus to digitalis induced Dr. Fraser to employ the drug with the view of discovering whether it could be used as a substitute. This was done in a large number of cases. In most of the cases Dr. Fraser employed a tincture made, by percolation, with the quantities prescribed in the *British Pharmacopœia* for tincture of digitalis. He also used watery and alcoholic solutions of strophanthin, and in a few instances injected this active principle, dissolved in water, under the skin. Accompanying Dr. Fraser's article is a report of five cases of heart trouble showing the improvement in the condition of the patients under the use of the drug, and, also, a number of pulse tracings showing a remarkable improvement in the circulation. The result of Dr. Fraser's clinical observations and pharmacological experiments goes to show that strophanthus exerts a much more powerful action upon the heart, and a less powerful action upon the blood-vessels, than digitalis. The exact significance to therapeutics of this difference Dr. Fraser is not prepared to say, but on first consideration the advantage seems to belong to strophanthus, in the treatment of cardiac disease at any rate. In difficulties and embarrassments of the circulation depending upon a central cause it seems to Dr. Fraser preferable to act on the heart alone, rather than also to increase its difficulties by closing the blood-vessels into which it must empty itself. "It may possibly be the case that some of the benefit which digitalis might otherwise cause, is antagonized, as it were, by the action it so strongly produces upon blood-vessels; and that this latter action may even render large doses dangerous, when they are given to a much weakened heart."

The Case of Dr. A. E. M. Purdy and the Health Department of New York City.—*Apropos* to the remarks made in our last issue in regard to the importance of a Medical Defence Association, to look after and protect the interests of the medical profession, the case of Dr. A. E. M. Purdy and the Health Department of New York City seems to

us to teach a most important lesson. The facts upon which we comment are these: Some three years ago Dr. Purdy, a well-known and esteemed physician, gave notice to the Health Department of New York City, in accordance with a regulation of the sanitary code which makes it the duty of physicians to notify this Department of cases of infectious diseases, that in his opinion, a young woman who was under his treatment was suffering with small-pox. The Department sent one of its medical officers to investigate the case. The diagnosis made by Dr. Purdy was then confirmed and by the authority of the Board of Health the patient was transferred to the small-pox hospital. After a day or two the patient was discharged. This patient immediately brought suit against Dr. Purdy for $10,000 damages, on the ground of injury to her business and of the false diagnosis upon the part of her medical attendant. The jury which tried this case gave a verdict of $500 against the defendant. The singular injustice of this verdict resides in the fact that damages should have been brought against Dr. Purdy, when in point of fact the injury to the plantiff was inflicted by the Health Department, which not only affirmed the diagnosis of the attending physician, but caused the removal of the patient to be made to the small-pox hospital. It appears that Dr. Purdy's sole error in the case was in informing the Health Authorities of the possible existence of small-pox. In the discharge of a duty imposed upon him by a city ordinance he has been subjected to the expense and annoyance of a legal case and has been mulcted by a jury to the extent of $500. It does seem to us that this is as flagrant a piece of high-way robbery as could be committed upon the rights and property of a citizen. There seems be not a single extenuating circumstance to lesson the monstrous wrong which has been imposed upon this physician for informing the Health Department of a large city of the existence of a case of small-pox. We believe, as a rule, medical men are as law abiding and observing as any other class of citizens. Moreover, we believe that the medical profession is called upon to make greater sacrifices of personal comfort and self-interest to protect the public health, than any other class of citizens, yet we observe that one of our number is ignominiously mulcted by a jury of his fellow citizens for his disinterested effort in behalf of the public health, and for the faithful performance of a duty imposed by law. Under the circumstances mentioned it would seem that as a profession we have few rights indeed, and that we are as liable to be punished for obeying as disobeying the laws of the community in which we reside.

We are pleased to notice one extenduating circumstance, in connection with the injustice done Dr. Purdy, in the fact that his friends have taken his cause in hand by extending assistance in carrying the case to a higher tribunal. The Medical Society of the County of New York has acted promptly and wisely in appropriating $500 to aid in further legal proceedings. This seems to be one of those cases in which the profession should assume the wrongs imposed upon its indival member and emphatically resent the injustice as a stab at professional liberty.

Miscellany.

Fistula in Ano.—At a meeting a of the New York Surgical Society (*New York Medical Journal.*) Dr. Lange directed attention to one way of treating fistula in ano, namely, cutting the entire canal out and sewing up the wound. In most cases it was a simple procedure, and he would be much obliged if the members of the society would try it. He had adopted it for the first time about two years before in the case of a woman who had a deep-seated fistula. In that case he had a complete result, and the patient recovered in about fourteen days. He had tried it in a limited number of cases, but he had not succeeded in all; yet he thought that, with improved technique, the results would become better. So far, at least, the results were encouraging. Having a probe in the canal, he dissected all about the probe and cut the entire fistulous canal away, including

some of the tissues surrounding it, and then, with a catgut étage suture closed the entire wound, and besides inserted several silk sutures around the whole mass, as after other plastic operations, to relieve tension and prevent eventual separation of the lips of the wound in consequence of too early absortion of the catgut.

Death or Coma.—The close similarity which is occasionally seen to connect the appearance of death with that of exhaustion following disease, was lately illustrated in a somewhat striking manner. An infant, seized with convulsions, was supposed to have died about three ago at Stamford Hill After five days' interval, preparations were being made for its interment, when, at the grave's mouth, a cry was heard to come from the coffin. The lid was taken off, and the child was found to be alive, was taken home, and is recovering. Such is the published account of the latest recorded case of suspended animation. We need not now attempt a dissertation on the physical meaning of coma. It is well-known that this condition may last for considerable periods, and may at times, even to the practised eye, wear very much the same aspect as death. In the present instance, its association with some degree of convulsion may easily have been mistaken by relatives, dreading the worst, for the rigid stillness of rigor mortis. This is the more likely, since the latter state is apt to be a transient one in infants, though it is said to be unusually well marked in death from convulsions. One cannot, however, help thinking that the presence of the various signs of death was not, in this case, very carefully inquired into. It is hardly possible that, had the other proofs as well as that of stiffening been sought for, they would have been missed. It is true that hardly any one sign short of putrefaction can be relied upon as infallible. In actual death, however, one may confidently reckon on the co-existence of more than one of these. After a period of five days, not one should have been wanting. Besides rigor mortis, the total absence of which, even in forms of death which are said not to show it, we take leave to doubt, the *post-mortem* lividity of dependent parts affords sure proof, as its abscence suggests a doubt, of death. Then there is the eye, sunken, with glairy surface, flaccid cornea, and dilated insensitive pupil. Most practitioners, probably, are accustomed to rely upon stethoscopic evidence of heart-action or respiration. These alone, indeed, are almost always sufficient to decide the question of vitality, if they be watched for during one or two minutes. There is no information as to whether the child so nearly buried alive was seen by a medical man. It is difficult to believe that, if it had been, some sign of life would not have been observed. Still, the case is a teaching one, even for medical men, and warns us to look for a combination of known tests where any doubt exists as to the fact of death.—*Brit. Med. Journ.*

Intra-Parenchymatous Injections in Pneumonia.—If, says, Lépine, an injection of a few centimetres of a very weak aqueous solution of corrosive sublimate be made into the hepatised lung on the third or fourth day of the disease, in three or four places equidistant a few centimetres from one another, and preferably at the periphery of the lesion, with a view of preventing the extension of the disease, the following phenomena are observed: 1. At the seat of infection an immediate diminution of the crepitant râles and tubular breath sounds which are in part replaced by respiratory silence and some larger râles; 2. sometimes, later, a transient exacerbation of the temperature of body; 3. the next day a great improvement in the general condition, and notably a precocious defervescence; and 4. a resolution which, to judge by the persistence of the "souffle," especially in the hepatised parts that have not been treated, takes place very much earlier than would have been the case under ordinary circumstances. As to the relative innocuousness of the intra-pulmonary injections in the doses employed (20 to 25 cubic centimetres of 1 in 40,000 solution of bichloride of mercury), when care is taken to keep away from the large vessels at the hilus of the lung, and not to penetrate the

lung more than 3 to 4 cm. ($1\frac{1}{5}$ to $1\frac{3}{5}$ in.), M. Lépine urges that he has not lost a single patient and has not had one accident. The only inconvenience is the pain, but this is not great, and may be still further relieved by adding morphine to the solution. After the introduction of the sharp needle, and before the syringe is fitted on, a few drops of blood are allowed to escape; the injection must not be delayed or the needle will become plugged. When the needle is inserted into healthy lung or into tuberculous lung it does not as a rule yield blood. In the healthy lung such injections produce sufficiently defined lesions. Experiments on the lungs of healthy dogs showed that at the site of injection of a rather stronger solution than that mentioned above, there was a strong circumscribed and indurated area, which was made of blood and congestive œdema. The lesions were less marked with the 1 in 40,000 solution.—*Lancet.*

Nephorotomy for Total Suppression of Urine.—Mr. Clement Lucas performed an unique operation in Guy's Hospital on October 29th. A woman, from whom he had removed the right kidney for the total destruction of its secreting structure by large calculi and hydronephrosis, about four months ago, and who had made a rapid and complete recovery, was suddenly seized with great pain in the left kidney, followed by vomiting, headache, and suppression of urine. She passed urine last on Sunday morning, October 25th, between eight and nine o'clock; and, from that time till the operation on Thursday afternoon, no urine passed, and vomiting was persistent. Her medical attendant, Mr. Atkins, of Sutton, correctly interpreting the meaning of her symptoms, placed himself in communication with Mr. Lucas, and the patient was brought to London on Wednesday, October 28th. It was thought that the effect of diuretics in flushing the kidney might yet be tried whilst the patient was watched. These proved of no avail, and on Thursday afternoon, the patient having become drowsy and much weaker, Mr. Lucas cut down the remaining kidney, and removed from the pelvis a conical calculus, measuring seven-eighths of an inch by one-half in its greatest diameters. Total suppression had then lasted 102 hours. A free flow of urine took place at once through the wound, and the patient was then relieved of her vomiting and drowsiness. Five days after the operation she was doing well and feeling comfortable. Mr. Lucas's case of nephrectomy performed October 20th healed without suppuration or fever. The patient sat up for the first time on the eighth day, and is now convalescent. —*Bristish Medical Journal*, November 7, 1885.

A Correction.—Dr. J. R. Quinan, of this city, kindly sends us the following correction: "On page 499 of the Journal of the 17th of October, you charge yourself with an error in having announced the death of Dr. John L. Atlee, of Lancaster, Pa., in your issue of July 25th; which death you say did not occur till October 1st.

Your error lay in confounding Dr. John L. Atlee, *Junior*, with Dr. John L. Atlee, *Senior*. The former *did* die July 25, last; and the later October 1. The son was 55 years old at death, and though an intelligent physician, never attained the distinction of his father.

Excision of the Uterus for Cancer. —*The British Medical Journal* says: On October 30th, Mr. Jennings excised the entire uterus (*per vaginam*) for cancer of the cervix, upon a patient under the care of Mr. Drowse, at Acton. He was assisted by Messrs. Drowse, Shaw, and Dove. Bichloride of methylene was administered by Dr. Fenton-Jones. The entire operation lasted about an hour and a half. Sir Spencer Wells saw the patient forty-eight hours afterwards in consultation, and gave a hopeful prognosis, which has proved correct. The notes of the case will be published in full in due course, together with an improved method of performing the operation.

Medical Items.

A number of cases of small-pox have been discovered in New York City, during the past month.

M. Brown-Séquard stated at a recent meeting of the Paris Biological Society, that in addition to the well-known effects of intoxication from coffee, he has observed anal and vulvar pruritus.

Dr. Wm. Frothingham, of New York City, accidently killed himself, on November 18th, while cleaning a pistol. He was an eminently successful practitioner and his sudden death has aroused much sympathy among his many friends.

From statements made at the recent meeting of the New York Charity Organization Society it appears that at least one-third of all who apply to our medical institutions for aid are unworthy of free treatment. It was also stated that the average physician spends at least one-third of his time in charitable work.

The Lackawanna Medical Society, at its recent meeting held at Scranton, Pa., passed a resolution condemning the action of the committee of the American Medical Association, in soliciting supports for its action regarding the International Medical Congress.

The *Medical Record* reports $7,759,91 at the net amount of cash subscriptions to the Sims Memorial Fund. This amount is said to be sufficient to erect a suitable bronze statue to Dr. Sims, and the necessary steps to that end will be taken by the committee without further delay.

Dr. A. Walker, says in the *British Medical Journal:* "In a number of cases, strychnine administered along with iron for a month before labor, has exerted a remarkable influence in preventing *post partum* hæmorrhage, where severe flooding has occured in previous labors."

At the age of nintey-four Dr. Neyron performs the duties of Professor of Anatomy in Notre Dame University, Ind. He was a surgeon in Nepoleon's army at his Russian campaign and Waterloo. Afterwards he became a priest and served as a missionary in the Northwest. —*Detroit Lancet.*

Painting the pharynx with a two-per cent. solution of cocaine, according to Dr. Lafosse (*Bulletin Générale de Thérapeutique*, August 15, 1885), entirely prevents the production of dyspnœa during the introduction of the stomach-tube; and, since this procedure is every day becoming more frequently employed as a therapeutic measure, it is well to know that the discomforts attending its use may largely be done away with by the employment of cocaine.—*Boston Med. and Surg. Jour.*

Mr. Lawson Tait states in the *British Medical Journal* (November 14th) that he has used the ligature in dealing with the pedicle in ovariotomy many hundreds of times, and that he has never had after-bleeding but in one instance, and that was due to his not using the Staffordshire knot. He prefers the ligature to the cautery. Mr. Tait also states that he has performed ovariotomy one hundred and thirty-two times since January, 1884, without a death and without any incomplete operation in the whole of that long series. This record is without a parallel.

The New York Academy of Medicine has had for a number of years a custom of having an anniversary discourse delivered by some one of its members. This custom was omitted for several years until the present year. The Anniversary Discourse this year was delivered by Dr. Henry D. Noyes on the subject of "Path-finding in Medicine." At the close of this address Dr. Fordyce Barker gave a history of this custom and made pleasant reference to one or two orations, especial reference being made to the one delivered by Dr. J. Marion Sims, in 1857, who included in his oration the history silver suture. "While Dr. Sims was speaking one of the ladies sitting by the side of Dr. Barker asked 'what is this silver suture?' to which Dr. Barker replied that it was 'a new-fashioned back-stitch.'"

Original Articles.

TUBERCULAR ULCERATION OF THE RECTUM.*

BY S. T. EARLE, M. D., OF BALTIMORE.

Although tubercular affections of the intestine, showing themselves usually as more or less extensive ulcerations, have long been known as a very constant accompaniment of advanced pulmonary tuberculosis, still, pathological changes in the mucous membrane of the rectum, due to the action of the tuberculous virus, have not received at the hands of the special writers on rectal diseases that attention which their importance merits. Tuberculous ulcers in the rectum are usually found in conjunction with similar ulcers in the small intestine in the neighborhood of the ileum, but may be found without any involvement of the small intestine. In all cases there is advanced tubercular disease of the lungs. Tuberculosis of the larynx and intestinal tracts have certain favorite seats, which may be explained in accordance with what we know of the tubercular virus. It is supposed that the sputum is the carrier of the infection, and the disease is most apt to appear in those parts which are most exposed to its action. Thus in the larynx the most frequent seat of the ulcerations is the posterior portion where the sputum rests longest in contact with the mucous surface. In the small intestine the ulcers are most frequently found near the cæcal valve, because here is found the most lymphoid tissue which seems to have but little power of withstanding the action of the virus. The ulcers are more frequent in the rectum than elsewhere in the large intestine, because here the virus is longer in contact with the mucous membrane. The virus enters the rectum either as contained in the swallowed sputum, or coming from the products of ulceration higher up in the bowel. If the rectum is carefully examined in all cases of tuberculosis, the number of times that ulcerations are found in it is much greater than is generally believed. Out of 260 autopsies made at Bay View in 1884 and 1885, tubercular ulceration of the rectum was found *twenty-six* times. Out of this number of autopsies pulmonary tuberculosis was found *ninety-two* times; all tuberculosis of the lungs being included, and not such cases only where death resulted in consequence of it. From this it seems that the rectum is affected in *about twenty-five percentage*, and if only those cases where death resulted from the tuberculosis were reckoned, the percentage would be much higher. In nineteen times tuberculosis of the colon accompanied that in the rectum, and twice was found without any rectal trouble. In *thirty-three* cases there was ulceration in the ileum.

The rectal ulcers are rarely single, in most cases several in number. They may be found in any portion of the bowel, sometimes just within the anus, but are most frequent several inches (two to four) higher up. There are two forms of ulcerations met with. The most frequent form is similar to the typical form of tuberculous ulcerations met with in the mucous membranes generally. The ulcers vary in size from a pin's head up to that of a half dollar or larger. They are generally oblong, and their long axis corresponds with the long axis of the bowel, showing in this a marked difference to those in the ileum, whose long axis is generally transverse. Their edges are rough, irregular, and may be slightly undermined. The base is rarely clean, but usually contains more or less caseous necrotic material. Although this is the usual appearance, cases are met with where the edge of the ulcer is clean and sharp, the whole having the appearance of being punched out. Here and there, both in the base and edges, small greyish white points are seen, which on microscopic examination are found to be miliary tubercles. The ulcers vary in depth, at times only involving the mucous membrane, or extending down deeply into the muscular coat. The ulceration advances by the continual formation of tubercles and inflammatory infiltration of the tissue around these, then the breaking down of both tissue and tubercles in-

*Read before the Clinical Society of Maryland, December 4, 1885.

to the ulcer. The extension in depth takes place in the same manner. The starting place for the ulcers seems to be the solitary follicles in which, on microscopic examination of the tissue between the ulcers, tubercles will often be found when there is no trace of them macroscopically. These are the ulcerations most frequently seen. They are in no respect, neither in their origin or growth, different from those found in the small intestine. In a certain number of cases another character of ulceration was found which differed in all respects from that just described, and the ulcers had nothing about them which we are accustomed to regard as characteristic of the tuberculous ulcer. These were found in but three cases, all of which happened to be negroes. The ulcers were more frequent than in the ordinary form, were, as a rule, shallower. What was particularly striking was the apparent acuteness of the process; the mucous membrane between the points of ulceration was swollen and injected, in some cases covered with a slight fibrinous exudation. The ulcers appeared to result from the simple breaking down of this swollen and injected mucous membrane.

The three cases were: 1st. J. B., col., æt. 35. In apices of both lungs large ragged cavities, elsewhere in lungs areas of caseous consolidation and miliary tubercles. Miliary tuberculosis of pleura, liver, spleen and peritoneum. The ileum contained numerous ulcers. The colon was ulcerated in numerous places. The rectum contained in its upper portion tolerably deep ulcerations, some of which were as large as the thumb-nail, others very minute. Most were shallow and had more the character of erosions. They were so frequent that in some places only small islands of intact mucous membrane remained. In the neighborhood of the anus the ulcers were not so frequent as they were higher up.

2d case. A. B., col., æt. 19. Both lungs contained large cavities and caseous nodules. Liver and spleen miliary tubercles. Kidneys, liver and spleen were amyloid. The mucous membrane of ileum swollen and injected, and contained numerous small ulcers and white opaque tubercles which had not yet broken down. The mucous membrane of the large intestine throughout its whole extent, but especially in the rectum, swollen and injected. Here were numerous small ragged superficial ulcerations.

3d case. J. B., col., æt. 35. Left lung in apex large cavities, elsewhere caseous consolidation and miliary tubercles. In right lung consolidation with tubercles. In larynx tuberculous ulceration. In ileum mucous membrane injected and contained a few ulcers. In the lower portion of the large intestine and in the rectum there was swelling of mucous membrane, intense hyperæmia and numerous small ulcers.

The microscopic appearances of these ulcers offered many points of interest. In most cases anatomical tubercles were found in or about the ulcers. There was an intense small cell infiltration of the mucous and submucous coat. Many of the glands of Lieberkühn were filled with cells. Where the small cell infiltration was greatest the tissue did not stain brilliantly, and appeared as if in the condition of beginning caseation. Some of the cells were large, pale and epitheliod in character, similar to those filling the alveoli of the lung in caseous pneumonia. In a few sections well defined tubercles with giant cells were found, and sometimes aggregations of small cells with a caseous centre. On staining the sections for tubercle bacilli enormous masses of these were found in the edges of the ulcers. In some places they were found in the infiltrated mucous membrane, where as yet there was no breaking down and where the small cell infiltration was the only pathological condition. Where they were found in greatest abundance caseation and destruction of tissue accompanied them.

This condition of the rectum seems to us to be an important point, for it shows that the tuberculous process in mucous membranes, as well as in the lungs, can advance independently of the formation of miliary tubercles. It is interesting to note also the similarity between the large cells found here and in caseous pneumonia. In the rectum in these cases, just as in the lung, we have to do

with an inflammation on which a specific character is impressed by the presence of the bacilli. In the ordinary tubercular ulceration of the rectum the bacilli can always be found on careful search in the abundant miliary tubercles, but, also, in many cases around these.

Various authors have described non-tubercular ulceration in the rectum, occurring in phthisical subjects, the ulceration of the *tuberculous* as distinguished from tuberculous ulceration. It has not been our fortune to meet with such ulcers. In the three cases last described, the ulcers, were not anatomically characterized by the presence of miliary tubercles, still the presence of the tubercle bacilli, and the ulceration so evidently dependent upon them, leaves no doubt as to the character of the process. It is probable that this idea of simple ulceration of the rectum, not due to tuberculosis, but to the tubercular diathesis, to a weakness of the tissues, has arisen from imperfect anatomical observation, and it must be relegated to the general storehouse of old ideas concerning tuberculosis. In some rare cases tubercular ulcers of the small intestine can, and do, heal, leaving behind a great deal of contraction and cicatrization. In many cases ulcers are found which show a cessation of advance with some attempts of separation. It is probable that in some exceptionally favorable circumstances the rectal ulcers may also heal with cicatrization. We have not met with any cases in which there seemed to be even a beginning of such a process.

Diagnosis: These ulcers are found in various parts of the rectum, without any special selection as to location.

According to Kelsey, "their favorite site is the verge of the anus;" but in our cases they have been seen here very seldom. They may be seen very distinctly by the aid of a good rectal speculum. Clinically, they present several appearances, which, while not pathognomonic, yet when taken in connection with the history, the diagnosis can usually be made. They may appear either as small, round, clean-cut ulcers, with the appearance of the tissues having been punched out, or as large irregular ulcerations, with ragged and everted edges, having the bottom covered with a greyish, dirty looking matter.

In neither of the above varieties is there much redness, or inflammation in the tissues around the ulcers, but on the contrary, they are rather pale.

The clinical appearance of the three cases specified in this paper was entirely different from those just described. In these there was intense redness and hyperæmia of the mucous membrane, with frequent points of superficial ulceration. The only absolutely pathognomonic sign clinically in all cases of tuberculous ulceration, is the presence of tubercle bacilli in the matter taken from the ulcers.* The symptoms are few and bear but little relation to the amount or extent of the trouble found within the rectum. Frequently we have found patients with several large ulcers in the rectum, who did not complain of any special symptoms referable to that part, and were only troubled with occasional attacks of the ordinary diarrhœa. Generally, however, it is attended with burning pain in the rectum, with some tenesmus, and a discharge of a small amount of pus, mucous and blood, with the usual fæcal operations; this last symptom is not, however, persistent even in the cases where it does occur. Diarrhœa does appear, but is intermittent in character, and is more likely due to the ulceration in the ileum and colon, which, as we have shown, is nearly always present, than to that in the rectum. The treatment is generally only paliative, as in most all cases the appearance of the ulcers in the rectum is only secondary to the existence of tuberculosis elsewhere in the body, and that, too, generally after it has made considerable progress in those localities. Should we, however, be called upon to treat a case where the general tuberculous cachexia is but slightly developed, we should make applications of a solution of bichlor. of mercury, one to one thousand, through a speculum, directly to and freely upon the ulcerated surface, every

*This can be readily obtained by scraping the bottom of the ulcer with a scapel, or scoop, during the examination with the speculum.

alternate day. Should also use suppositories of opium and iodoform, two or three times daily, as occasion required; the former only in cases where there is pain and tenesmus. These suppositories may also be used as paliative measures in those cases where the general tuberculosis has advanced so far as to leave but little hope for any permanent good results from any kind of treatment.

Selected Articles.

ACUPUNCTURE, AND ITS APPLICATION IN THE TREATMENT OF CERTAIN FORMS OF CHRONIC RHEUMATISM.*

BY G. LORIMER; M. A., M. D. EDIN., BUXTON.

Read in the Section of Medicine at the Annual Meeting of the British Medical Association in Cardiff.

It is proposed, in the following paper to make some remarks on acupuncture; to consider its application in the treatment of certain forms of chronic rheumatism; to cite illustrations, with which the writer's experience has furnished him, of its successful employment in the affection in question; to indicate the cases in which favorable or negative results may be anticipated from its use; and, finally, very briefly, to advert to views which have been entertained in regard to its *modus operandi*.

Acupuncture is no new remedy. It was used by the Chinese and the Japanese from ancient times, and, together with the moxa, constituted the two pillars in their system of therapeutics. It was introduced from Japan into Europe, about 200 years ago, by Ten Rhyne, a medical officer in the Dutch East India Company's Service, and his account of it is recorded in a *Thesis de Arthritide*, published in London, 1693. Karmpher, in his *Amœnitates Exoticæ*, published 1712; Dujadin, in his *Histoire de la Chirurgie* (1714); and Vicq D'Azyr, in the *Encyclopédia Méthodique*, make mention of the subject.

It was in France that it first received practical effect. Dr. Haime, of Tours, and Berloiz, of Paris, made trial of it; the former published the accounts of his cases in the *Journal Universel*, 1819, and the latter communicated his results to the Academy of Medicine about the same time; and, in a *Memoire sur les Maladies Chroniques, les Evacuation Sanguines, et l' Acupuncture*, commends its efficacy and promptitude, but refers to its inutility in inflammatory diseases, and those attended with sanguineous turgescence. Subsequently M. Jules Cloquet and his pupil, Dr. Dantu, practised it extensively at the Hospital Saint-Louis. M. Jules Cloquet has, in a monograph, recorded his experience in regard to it, and alleges that, of 129 cases treated by him, twenty-nine were cured.

Mr. Scott, a surgeon in Westminster, appears to have been the first to employ it in England, at the early part of the present century; and, shortly afterwards, Mr. Morris Churchill published an account of cases which he treated by it in a vigorous pamphlet, subsequently followed by a second, in which he continued to advocate its use, and also replied to certain objections alleged in regard to it.

It is, however, to Dr. Elloitson that we owe the best account of the subject. In an able and interesting article in the *Cyclopædia of Anatomy and Surgery*, he has placed together all that is known in regard to it, along with his own experience of its use at St. Thomas's Hospital.

Trousseau, in his *Clinical Lectures*, refers favorably to its use in the treatment of neuralgia, but in modern times, it seems to be entirely disregarded and forgotten. The more recent notices in regard to it are from Mr. Snell, of Sheffield (*Medical Times and Gazette*, 1871), and Mr. Pridgin Teale, of Leeds (*Lancet* 1871), and both advert to the fact that it has passed into disregard and disuse.

Why acupuncture has passed into neglect it is not easy to explain. It may be that, in some conditions for which it has been used, it has been superseded by other and better means: for instance, by

**British Medical Journal*, November 21st, 1885.

hypodermic method of treatment. It may be that it has suffered at the hands of charlatans; and it may be,as has been suggested, "that there is some general disinclination to use a remedial agent whose *modus operandi* cannot, in some way, be connected, analogically or otherwise, with that of the remedies which common use or universal experience has sanctioned." Be this as it may, the fact remains that acupuncture has passed out of fashion; and it is hoped to be shown that it has undeservedly passed out of fashion, and that, in suitable cases, it is still a prompt, efficient, and reliable remedy.

It is not intended to enumerate all the applications of acupuncture in the treatment of diseases, for many of which it is now superseded by more efficient means. It is used with success, and sometimes, too, with signal success, in the treatment of sciatica; and of its efficacy in the treatment of this affection from repeated trials, I am fully convinced; but it appears now to be eclipsed by the more formidable process of nerve-stretching.

It is, however, to its application in the treatment of chronic rheumatism, that my remarks will be limited; and in reference to this subject, Dr. Elloitson, in volume xiii of the *Medico-Chirurgical Transactions*, has well observed: "Acupuncture is chiefly useful in rheumatism of the fleshy parts—rheumatalgia—and the more so as the disease is less inflammatory. Indeed, when the parts are hot, or the pain is increased by heat, the remedy is generally useless, and cannot supply the place of antiphlogistic measures. The effects are sometimes magical. The pain sometimes ceases while the needle is in the flesh. Of forty-two cited from his practice at St. Thomas's Hospital, thirty were cured, and the other twelve were clearly not adapted for it, there being much heat of the affected parts."

My experience is in full harmony with the preceding remarks; but in further referring to this portion of the subject I wish to summarise briefly the results at which an extensive experience in its use has led me to arrive.

In chronic rheumatism of the muscles and their fasciæ, and aponeuroses, there are usually three conditions present; 1, pain; 2, impaired mobility or muscular disability; and 3, impaired nutrition leading to muscular atrophy. The last condition is not always present, and is most marked in cases of a pronouncedly chronic character. The first two conditions may occur separately or conjointly. They may co-exist in equal degree, or they may occur each in greater or less degree.

Acupuncture may be employed with advantage for the relief of pain for the removal of muscular disability; and, with the removal of the latter condition, muscular atrophy is usually improved. Acupuncture, however, is less certain and efficacious in the relief of pain, than in the treatment of muscular disability. For the relief of the latter condition, however, as well as sometimes for the former in rheumatism of the lumbar muscles, of the muscles of the thigh, and in rheumatism of the muscles of the arm and shoulder the effects are sometimes signally efficacious.

With regard to the last mentioned situation (namely, the shoulder), the relief from muscular disability is most marked when the disablement is referred to a point situated in the central or lower part of the deltoid muscle. When situated in the upper part, relief is less frequent, and, when above the scapular spine, it is very seldom obtained. The certainty of relief is in proportion to the limited area of obstruction to movement; if, however, the area of obstruction to movement to be extended and indefinite, success is less likely to result. In some cases, galvano-puncture succeeds when acupuncture fails.

After the removal of the needle, at the seat of puncture there frequently appears a red areola, from half an inch to two inches in diameter. The appearance of this areola, bears a direct relation to the success of the operation. It is generally absent in cases where the action is inert, and the result negative.

In the removal of muscular disability, the action of acupuncture is immediate. The maximum amount of muscular power, however, obtained from its appli-

cation is gradual, being from ten minutes to one hour after the removal of the needle.

It is doubtful if any benefit is obtained from retaining a needle beyond two minutes in the treatment of cases of muscular disability; more benefit is obtained from increasing the number of needles than prolonging the time of their insertion. With regard to relief from pain, however, the converse is true.

When extensive muscular atrophy is present, relief is doubtful. When the latter condition is present, and is an obstacle to improvement, galvano puncture may succeed after acupuncture has failed. For the relief of pain, several applications may be required, each of some hours' duration. Cases which most frequently receive benefit in relief from pain are those of subacute inflammation of fibrous tissue, myalgia, and anomalous forms of rheumatism, which sometimes attack the surrounding structures of articulations subsequently to injury. In some instances, after the application of acupuncture-needles, pain may be removed, but it may pass to the corresponding situation on the opposite side of the body.

After the application of the needle, there is generally experienced, at the point of insertion, and for some distance from it, a feeling of coldness or numbness, or a sense of prickling or heat. Syncope seldom occurs from the employment of acupuncture.

Acupuncture is less frequently followed with beneficial results in muscular disability, and muscular atrophy consequent on sciatica.

The needles employed are about two inches in length, or longer. They are set in round handles, and should be introduced with a gentle rotatory motion. Those now used by the Japanese are made of gold, which is an unnecessary extravagance.

I would now cite some cases from an extensive experience in the subject, in order to show the efficacy of acupuncture, and to illustrate the preceding remarks.

Case I.—Male, aged 55, had suffered from chronic rheumatism for three years. This complaint had become localized in the right shoulder, and, for nine months preceding, he had been unable to raise his elbow for more than a few inches from the side. The impediment to raising his arm was referred to an obstruction felt in the middle of the deltoid muscle. Two acupuncture-needles were introduced, and retained for two minutes. In five minutes after their removal, he could raise his hand to touch the back of his head.

Case II.—Male, aged 19, had suffered from chronic rheumatism for some months. For seven weeks he had been unable to raise both elbows, except a few inches from the side. The obstruction was referred to the middle and posterior aspect of the deltoid. Two acupuncture-needles were introduced, and retained for one minute. In two minutes, after removal, he could raise both arms with comparative ease.

Case III.—Male, suffered from chronic rheumatism, consequent on an acute attack occurring eighteen months previously. He had been unable to raise his right arm from obstruction and pain, referred to the middle and lower third of the deltoid. Three acupuncture-needles were introduced, and retained two minutes. After their removal, he was able to raise his arm at once to his head; the pain subsequently passing away.

Case IV.—Male, aged 42, had suffered from chronic rheumatism for six months, consequent on an acute attack. The disease had become localized in the left shoulder, and for two months he was unable to raise his arm. There was some muscular atrophy of the deltoid and biceps. Four acupuncture-needles were introduced into the points which were felt to impede the raising of the arm—namely, in the upper third of the biceps, and middle of the deltoid muscles. After remaining for two minutes they were withdrawn, and it was found that he could raise his arm with comparative ease.

Case V.—Male, aged 57, had been unable to raise his arm for three months in consequence of chronic rheumatism, affecting the right shoulder. Three acupuncture-needles were inserted into the right deltoid, with the affect that, after their

removal, he was able to raise his arm without difficulty.

Case VI.—Male, aged 31, had suffered from chronic rheumatism for six months, and from stiffness and disablement in the muscles of the back, in consequence of which he was unable to rise from his seat without aid. Four acupuncture-needles were introduced into the points of impediment to movement, in the lumbar muscles. They were retained for two minutes, and, after their removal, he was able to rise from his seat without assistance and without difficulty.

Similar cases might be multiplied, but a sufficient number have been cited in order to demonstrate the efficacy of acupuncture in muscular disability. Reference must be made to cases in which negative results followed its use.

Case VII.—Male, aged 23, had suffered for three months from rheumatic pains. For six weeks he had suffered from loss of power in the right arm, inability to raise it, and loss of power in the muscles of the shoulder. He was unable to raise his arm, and, if it were raised by an assistant, he had no power to maintain it in an uplifted position. The arm dropped immediately. The muscles of the shoulder were well nourished. Acupuncture-needles were introduced without benefit. No red areola was observed on their removal. The patient ultimately recovered by the use of galvano-puncture.

Case VIII.—Male, aged 47, had suffered from chronic rheumatism for eight months. The muscles of the shoulder were wasted. He was unable to raise his arm; the impediment to movement being extended and general, and not referred to a fixed point or limited area. Acupuncture was employed with negative results. Some relief was obtained from the use of galvano-puncture.

Case IX.—Male, aged 40, had suffered from chronic rheumatism for several months. He was unable to raise his arm from an impediment of indefinite extent referred to the lower edge of the trapezius, above the scapular spine. Several acupuncture-needles were introduced into the lower edge of the trapezius muscles, and the supra-spinatus, where the obstruction was felt. The result, however, was negative.

In some cases, adhesions may be present, or the condition of the joint itself be a source of impediment to movement; and, if so, negative results may be anticipated.

It is next proposed to cite some cases where acupuncture has been used successfully for the relief of pain; in this, however, it is less reliable than in the treatment of the former condition.

Case X.—Male, aged 19, had pain in the os calcis and plantar fascia, consequent on gonorrhœal arthritis. The pain was of two months' duration. An acupuncture-needle was introduced on two occasions, and retained for two hours each time, with the effect of completely removing it,

Case XI.—Male, aged 25, had had chronic rheumatism of four months' duration. Pain was referred to the plantar fascia for six weeks. Two applications of acupuncture, each of one hour and a half duration, effected its entire removal.

Case XII.—Female, aged 29, had pain in the upper part of the right thigh, of eight months' duration. It was situated about six inches below the tuber ischii. She had suffered from chronic articular rheumatism for ten months. An acupuncture-needle was introduced into the seat of pain, and retained for three hours. A well marked areola continued after its removal. The pain entirely subsided, but recurred a fortnight subsequently in the corresponding part on the opposite thigh. A second acupuncture-needle was introduced, and retained for a corresponding period of time, with the result of entirely dispelling the pain.

Lastly, I wish very briefly to call attention to the views which have been entertained in regard to the *modus operandi* of acupuncture. Some have ascribed its action to derivation, others to counterstimulation. Haime and Cloquet believe that pains depend on unequal distribution of nervous fluid, and that acupuncture equalizes its distribution, thus giving relief. Dr. Bachu adopts this view, and thinks that the accumulation of nervous fluid is dependent on an altered state of the fascia. Others, again,

have ascribed its effects to moral influence.

Passing over these conjectures, I wish to notice the views which Mr. Teale, of Leeds, has proposed, to explain its action in the relief of pain, and in the removal of muscular disability. In regard to the former, it is held that injury or inflammation of the fibrous tissue has produced defective nutrition of the nerves pervading such tissue; the nerves are ill-nourished from improper blood-supply, and consequently painful. The needle produces a temporary active congestion, or flushing, of the vasa nervorum, and this acts as a starting point for improved nutrition, and consequent cessation of pain.

With regard to the removal of muscular disability, it is held that, the muscles being in a state of rest, the fibres waste from disease; the arteries, too, having less blood to supply, become diminished in calibre. In addition to the diminution of arterial calibre proportioned "to the reduced muscular bulk, there must be further diminution from the cessation of the demand for blood for carrying on active tissue-change, which accompanied the active work of the muscles. The arteries of the disabled muscles must have become reduced in calibre, in a degree greater than would be accounted for by the mere muscular wasting, so as to be capable only of nourishing the wasting muscles when at rest, and not when at work. The mere act of will is inadequate to force sufficient blood to give the muscles tone to act. This defective power of will, the stimulus of acupuncture supplies, by producing a temporary congestion, and corresponding increase in the calibre of the vessels and the blood-supply."

These views seem not improbable, and are not inconsistent with the conditions necessary for healthy action. How far, however, the *primum mobile* in the change is nervous agency, acting secondarily through the vascular supply of the affected muscles, is open to question.

In conclusion, it is hoped that, by calling attention to acupuncture, and to the cases in which it is suitable, in such it may receive further trials, and that it may not be allowed to pass, undeservedly, into disregard and disuse. It is a remedy which is proper and efficacious, and one which, in properly selected cases, will maintain its place.

Clinical Reports.

DEATH AFTER A PHIMOSIS OPERATION.

Dr. S. B. Bond, Chief of Clinic to the Professor of Surgery, University of Maryland, sends us the following report:

J. B., white, æt. 71, a resident of Charles County, Maryland, and a surveyor by occupation, applied to me for relief from an acquired phimosis. He was the father of nine children, and in spite of his age, had been able to make what he called a "big survey" a short time before coming to me. His prepuce, he stated, had begun to contract so as to give trouble, some two years before I saw him, and at that time the contraction had progressed so far as to leave but a very insufficient opening. The urine was retained, urine action was painful, the clothes were wet and the penis kept in a very uncomfortable state of irritation in consequence. Mr. B. was anxious for an operation and relief, and with the assistance of Dr. L. DeL. Gorgas, I did the ordinary operation of slitting up the surface along the anterior aspect as far back as the corona glandis and stitching the mucous membrane to the skin. There was almost no pain as the foreskin had previously been filled with a solution of muriate of cocaine. Bleeding was slight. The after-treatment consisted in water-dressing and elevation of the penis and scrotum, the patient being in bed.

The following I take from my record of the case.

March 26th, 11 A. M.—Mr. B. passed a very comfortable night, the incision looks healthy.

27th, 10.30 A. M.—Mr. B. complains of chilly sensation running from his feet to his neck. His night's rest has been broken in upon by unpleasant dreams, followed by periods of wakefulness. The penis seems to be doing well, and he stated that he was often a sufferer from

malarial trouble, and I acted accordingly.

28th, 4 P. M.—Condition as follows: pulse 80; temperature 105°; respiration about 24. Examination of his penis showed three bluish-black spots, one immediately behind the frenum about the size of a five-cent piece; one which is slightly smaller, half way between the first and the scrotum; and one on the scrotum at the junction with penis. The spots are superficial. The man lies with his mouth open and he has some muttering delirium from which, however, he can be roused. In answering questions his speech is thick and not easy to understand on account of the dryness of his throat. Dr. L. McL. Tiffany was called in; treatment confirmed.

29th.—Yesterday's "black spots" are areas of superficial gangrene to-day. The distal spot has become a slough; the odor is characteristic; the scrotum is uniformly involved and contains a considerable amount of fluid. B. can still be roused from his mutterings, but his replies to questions are unintelligible on account of the condition of his throat. Urine was passed in my presence to-day, but none was secured fit for examination. Probably half a pint was passed. His excretions pass either without his knowledge, or without being able to make himself understood when an operation is necessary. General condition is about the same as yesterday.

30th, 11 A. M.—No marked change. No sleep last night, and his throat apparently troubled him.

11.30 P. M.—About the same still, but has had no sleep to-day.

31st, 11 A. M.—B. slept several hours last night without resorting to opiates, and his condition is somewhat impaired in consequence.

12 P. M.—Decidedly worse.

April 1st, 10 A. M.—Sinking slowly.

5 P. M.—Dead.

One of the peculiar features of the case was the fact that the gangrenous spots did not begin where one would have expected them to, if at all, namely, at the side of the stitches or along the margin of the incision, but they occurred upon the posterior surface, in that situation which was most distant from the disturbing incision of any in the whole circumference of the penis. So far as I am aware gangrene after a phimosis operation is exceedingly uncommon, and I have reported this case, as fully as is possible from notes taken under rather disadvantageous circumstances, for that reason.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD NOVEMBER 20TH, 1885.

The meeting was called to order by the President, Dr. Tiffany, in the chair.

The following gentlemen were elected to membership of the Society. Dr. Wm. H. Welch, Dr. B. Bruce Wood, Dr. Thomas Perry, Dr. R. B. Nordman.

Dr. Michael then made some remarks on

DR. ELLIS PORTER'S SPLINT FOR FRACTURES OF THE FOREARM.

He did not consider it an absolutely novel idea, but thought it as good as any splint he had used. Dr. Porter, he said, claims for them simplicity and lightness, and that they permit a greater freedom of movement to the fingers. The splint is a parallelogram of wire braced near one extremity by a transverse bar of the same material. In using this splint it is first wrapped with an ordinary roller bandage; this converts it practically into a board with stiff edges and an elastic centre. The splint, after reduction of the fracture, is placed on the dorsal aspect of the extremity and held in position by a bandage. No padding is needed. But a single one of these splints is necessary in fractures of one or both bones of the forearm.

Dr. Winslow thought two splints better than one in forcing apart the broken fragment of radius and ulna.

Dr. Waters thought the same splint had been used during the war with the addition of a suspension apparatus.

Dr. Michael answered Dr. Winslow's criticism by pointing out that the splint practically acted in the same way as if two boards or splints were used. The splint *exceeds* the forearm in *width*—consequently, when with its elastic backing it is applied in the usual way, the only pressure, after the bandaging, is on the dorsal aspect, from the splint, and on the ventral aspect from the bandage used in holding it in position—the width of the splint preventing any lateral pressure. Thus we have the muscles compressed in exactly the same way as when two splints are used.

Dr. Winslow did not mean to reject the splint but only to say there are cases in which two splints are better than one.

Dr. Tiffany thought the splint under consideration a legitimate offspring from the Smith's Anterior splint.

Dr. Rohé reported a case of

ERYTHEMA MULTIFORME

presenting some unusual features.

He said the different clinical manifestations of erythema, formerly described as varieties of the disease, were probably merely stages of the morbid process, presenting in the one case diffused red patches, in another papules, in others tubercles, vesicles, blebs, or large tumors.

In some cases, all of these various lesions were present at the same time. Erythema nodosum, which preserved its individuality for a long time in the systematic works of authors, has finally yielded also, and must now be considered merely as a further stage of primary lesion, the erythematous spot. Erythema multiforme usually runs its course without causing much constitutional disturbance, unless it is accompanied by rheumatic symptoms.

Sometimes, however, there is high fever, digestive disturbance, headache, and in children even delirium or coma.

A case presenting the latter symtoms was related.

The case which prompted these remarks occurred in a medical student attending lectures at the College of Physicians and Surgeons. The eruption began on the back of the neck and scalp. These were bright red papules and tubercles with some burning but no itching. There was no eruption anywhere else on the first day. No constitutional disturbance. On the following day the redness of the skin on the back of the neck was more intense, some of the tubercles were capped by small blisters, and a number of papules and red spots appeared on the wrists and backs of the hands. There was some elevation of temperature and anarexia.

At night the temperature rose to 103° F.; there was a pretty severe headache and some joint pains, the latter, however, not being very violent. A few doses of sodium salicylate produced free sweating, reduction of temperature and disappearance of articular pains. The face now became covered with tubercular lesions of various sizes, one on the forehead being as large as an almond. All the regions of the skin affected were tender and painful. The hands were considerably swollen, and on account of tenderness, motion was almost impossible. The temperature on the following night rose to 104° F., but afterwards rapidly declined, and in a few days all the lesions had disappeared, followed by slight desquammation During the height of the disease the ankles and shins were also the seats of tubercules and nodose eruptions.

Dr. Earle had just had a case of erythema nodosum; it appeared first as a vesicular eczema and resembled chicken pox. It remained too long to justify this diagnosis, and more especially did it contraindicate such an opinion by giving away to erythematous eruptions which were confined to face and wrists.

Dr. Hiram Woods cited a class of troubles which had come under his notice and which he was unable to classify. They occurred in ill nourished children on the extensor surfaces of the lower extremities. It began as an erythematous patch, followed by a vesicle and a scab, and healed under the scab, which when removed leaves a brown discoloration that gradually fades away.

That they occur in children who wear shoes and stockings excludes the idea

that they are due to exposure of the limbs. They do not occur on the face.

Dr. Rohé looked on these affections as being most often due to insect bites They are again often caused by the material used in dying the stockings. It is his opinion that they occur most frequently in children of delicate constitution and that they are atonic. They rarely or never leave a scar.

Dr. R. Winslow showed a

PERIOSTEAL SARCOMA

from the lower jaw. There was no lymphatic involvement. The growth surrounded the body of the inferior maxilla on the right side and extended some distance up the ramus. The submaxillary gland being adherent was removed with it. In the operation he separated the mouth cavity from the wound cavity by suturing the mucous membrane of the mouth, independent of the skin incision. The man from whom the tumor was removed recovered.

Dr. Keirle thought it essential to success that one should have a considerable clinical, as well as a histological acquaintance with tumors before operating. In his opinion sarcomas of the lower jaw usually did well.

Dr. Tiffany said that a sarcoma in the lower jaw was less likely to recur than when occurring in any other bone in the body. The *reverse* is true of the upper jaw, why, he could not say.

TWO CASES OF ABSCESS.

Dr. Tiffany then related two cases of abscess. One occurred in a man æt. 74, who had trouble in passing his urine; about a week before he was seen, he had had frequent chills, followed by extreme swelling of the perineum. When he saw him he was in bed, with fair pulse and good tongue and a tremendously swollen perineum. To the left of the median line was a dark spot strongly suggestive of gangrene from infiltration of urine from rupture of the urethra consequent upon obstruction by a stricture. Palpation revealed this tumor to be a collection of gas. He punctured, gas escaped, which, upon applying a match, burned with a blue flame. He layed the tumor open, washed it out and made the man comfortable. The other case was an abscess in the thigh. Both cases were in individuals of fair constitutions. The latter case died six weeks after operation. The odor of the gas from this case was that of sulphureted hydrogen.

Dr. Michael thought a communication between an abscess cavity and the intestinal canal, or its formation near the intestinal canal, might account for the presence of the inflammable gas. He detailed a number of interesting experiments upon intestinal gases which go to prove their combustible nature.

Dr. Tiffany agrees with Dr. Michael that an abscess near the intestinal cavity would probably contain these gases. He had seen a case of intestinal obstruction which when tapped gave off a gas which burned.

Dr. T. P. McCormick had also had a case of abscess giving off inflammable gas. This was a supra-pubic abscess communicating with the intestines.

A CASE OF DIFFICULT DIAGNOSIS.

Dr. Earle related a case, interesting because of the difficulty of diagnosis. It was a case of malaria which appeared at first to be typhoid. For three weeks the temperature ran high, and then convalescence and recovery set in. The disease occurred in an insane patient at Bay View Asylum. Her mental condition was much improved after this attack. During convalescence she was retained in an apartment occupied by a typhoid case, as her condition was still supposed to be of that nature. After a few days bowel trouble set in and continued for ten days. Quinine had no effect. She had suppuration of her parotid glands. Autopsy revealed miliary tuberculosis especially marked in the abdominial cavity. No pigmentation of the spleen was seen. No ulceration at all in the bowel. He could give no reason for the parotid abscess. The time between the end of the first attack and the beginning of the second was four weeks.

Dr. Keirle referred to the fact that suppuration of the parotid occurred in typhus—it resembled carbuncular inflammation. It was a bad prognostic sign, usually indicating death.

He spoke of a case of bilious remittent which revealed the presence, at autopsy, of an ague cake and a marked cirrhotic liver.

Correspondence.

PROF. C. D. MEIGS AND THE OBSTETRIC FORCEPS.

BALTIMORE, Dec. 5, 1885.

Editor Maryland Medical Journal.

DEAR SIR:—In the interesting discussion that followed the presentation of an able paper, by Dr. G. W. Miltenberger, on the comparative safety of version and the high forceps in special cases, Dr. Wm. T. Howard took occasion, in the course of his remarks, as reported in the 247th number of the JOURNAL, page 103, to say he "remembered how vividly the late Prof. C. D. Meigs used to impress upon the class at the Jefferson Medical College the importance, in such cases, of having the forceps at hand ready for use, by relating a case, which is recorded in his work on *Obstetrics*, in which the child cried within the vagina, while his forceps were being sent for. The head was speedily withdrawn when he received the instrument, but too late to resuscitate the child." By depending too much on memory, in the hurry of a verbal discussion, Dr. Wm. T. Howard has (if reported right) done the memory of his and my venerable preceptor unintentional injustice, by confounding the relation of one of Dr. Meigs' own cases with his relation of another's. By looking at his Obstetrics, page 499, we read: "I have heard this *vagitus vaginalis* for many minutes, and, indeed, have in this manner (by pressing the fingers into the vagina to give access of air to the child) enabled the child to continue breathing until my forceps could be brought, from a considerable distance, wherewith to deliver the head." Then, on page 500 of same work, he relates a case seen in consultation, but which he did not reach till *after* the mother and child were both dead, the one from flooding, and the other from delay in obtaining the forceps by the *medical attendant*. As a classmate of Dr. Howard, in the session of 1844, in sitting at the feet of this Gamaliel of the Obstetric Art, my veneration for the reputation of our Common Master is too deep to permit this unintentional reflection on his success and skill to pass uncorrected, and I am sure Dr. Howard would himself make it, if his attention had been called to the *lapsus linguæ* in time.

JOHN R. QUINAN, M. D.

1362 N. Gilmor St.

OPERATION FOR EXTENSIVE LOSS OF SKIN IN THE ARM.—In 1883, N. L., during a very severe attack of phlegmonous erysipelas, lost the greater part of the skin of the inside of his right arm, from the posterior fold of the axilla down to within three inches of the wrist-joint. He came under my care with the view of having an amputation performed at or near the shoulder-joint. After months of treatment, however, by skin grafting, rest, etc., cicatrization had progressed, till only a wound about 3½ inches long by 1 broad remained inside of elbow-joint. This refused to heal any further, a dense cicatrix ringed in the arm for about three inches of its length, and the tissues around were constantly reopening. He again was admitted in June, 1885, requesting amputation. I thought it a pity to sacrifice a good hand, so determined to shorten the limb.

This I did by cutting down upon the humerus three inches above the elbow-joint behind, and removing subperiosteally the whole lower three inches, including the condyles and cartilage, and also the olecranon. He has now a useful arm with full flexion, extensive, pronation, and supination, shortened barely two inches, and healed.—*Edinburgh Medical Journal*,

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BALTIMORE, DECEMBER 12, 1885.

Editorial.

THE DESIGNATION "ALLOPATH" A MISNOMER WHEN APPLIED TO REGULAR PRACTITIONERS OF MEDICINE.—There is no word which so grates on the ears of a cultivated and scientific practitioner of the regular school of medicine as the designation, sometimes given to this school, of Allopath. The term, when applied to a scientific school of practitioners, is a misnomer, and its use is as incorrect as the principles it is supposed to represent. The day is past when scientific workers should be classed with men who hold absurd doctrines or cling to dogmas which are used more for purposes of trade than to represent distinct principles.

The term allopath was coined by Hahnemann to designate the ordinary practice of medicine as opposed to homœopathy. Hahnemann assumed that those who did not accept the doctrines of *similia similibus* were given to the employment of medicines intended to produce effects different from those resulting from disease. Having adroitly organized a dogma and a school after his own fanciful imagination, this founder of the homœopathic idea began by misstating the principles of scientific practice. The term applied by himself, and by his followers, has no truthful application to any class of practitioners.

So far as we know regular medicine is not hedged in by a creed or dogma, but its principles are as broad and liberal as the bounds of scientific knowledge will admit. We think it unfortunate that the practitioners of regular medicine should have rested under the ban of the allopathic idea without protesting in louder strains against its narrow and unjust designation.

It has come to be a fact, however, that the regular profession has allowed the homœopathic school to apply this term to all who differ with their peculiar dogma without resenting the absurdity of its application. It may be asked, what difference does it make what term is applied to the regular school? The answer appears in fact that the idea expressed by the term is deceptive, and classes those thus designated as followers of an exclusive dogma, to wit, that medicines are employed to produce effects different from those resulting from disease. The allopath, in other words, is supposed to practice under a trade-mark just as the followers of the Hahnemannian school thrive on the special distinction of homœopath.

It may not be known to all of our readers that allopathy was never accepted by regular medicine as a distinct principle of practice, but it is a fact that the designation has not been thrown over-board and repudiated by all of those who recognize the absurdity of the doctrines it is supposed to represent. The regular profession has so far acquiesced in its acceptance of the designation that to the general public we are known by no other name, and are supposed to be wedded to the dogma the name implies. Terms which bear erroneous constructions are prejudicial to the growth of an exact nomenclature and become distorted meanings for correct principles.

The present age is one of vast growth in art and science. It has witnessed the rise and fall of numberless theories and principles. It has introduced methods of scientific research which have wrought marvellous changes in our knowledge of the science and practice of medicine. It has cut loose from the doctrines of a

single mind, and made tradition and blind obedience to eminent authority things of the past. The teachings of Hahnemann have been discarded by many of those men who, a few years back, were most loyal to the homœopathic idea. The advanced men of this school have had the courage to cast overboard the special designation under which many of their lesser lights continue to trade. Their leading thinkers and practitioners have extracted whatever was of value in Hahnemann's therapeutic methods and have abandoned his dogma of *similia similibus* as a mere tradition. The so-called allopathic school has not existed unless it be in an imaginary sense, but it has rested under the designation of a allopathic idea so long that it has been assumed by many who practice regular medicine, and by the public, that our system of therapeutics was based upon the dogma the allopathic idea expresses.

When the medical profession reaches a platform from which it will assert that it practices scientific medicine and not systems of medicine and dogmas, we will have arrived at an intelligent interpretation of regular medicine. Down with the allopathic cognomen!

Mr. Erichsen's Candidature.—Our esteemed contemporary, the *British Medical Journal*, asserts that it has long been a common matter of regret, and sometimes of almost querulous complaint, that, neither directly nor indirectly, has the medical profession obtained any adequate representation in the legislature of Great Britain. Our contemporary is warm in its exposal of the claims of Mr. Erichsen, the eminent surgeon and author, who is a candidate for Parliament from the Universities of Edinburgh, and St. Andrew's. Mr. Erichsen is pronounced a candidate of exceptional excellence, not a mere party politician, but one who will worthily represent the great educational interests of the Universities. Mr. Erichsen has out-lined to his constituents the special interest which he would be able to take in legislative measures based upon medical and sanitary science. The abuse of medical charities, the inefficiency of the protection at present afforded to the public against unqualified practitioners, and the necessity for strengthening the hands and reforming the constitution of the General Medical Council are among the measures he proposes to consider should he be favored with a seat in the House of Commons. Our contemporary admits that upon all of these points his opinion as a representative of the medical profession, would be a valuable assistance to the legislature, and, therefore, urges that no opportunity of sending competent medical representatives to the new Parliament ought to be lost; "the reform of local government is one of the first questions which will occupy attention, and to which both parties in the State are pledged. On such a question, the voice of the medical profession ought to be heard, not only in the interests of the profession, but also, and chiefly, in the interests of the public—that great patient public which for generations past has suffered so much from the apathy and inadequate sanitary knowledge of party politicians."

Should Mr. Erichsen be favored with a seat in Parliament our professional brethren in Great Britain will have abundant cause for congratulation. It is so seldom that a medical man of Mr. Erichsen's attainments and eminence will consent to represent the medical profession in legislative bodies that the interests of the profession and of the public have greatly suffered for the want of that knowledge, experience and influence which such legislators possess. We have long desired to see the legislative bodies of our City, State and National Governments more fully and ably represented by members of our profession. It is quite true the political doctor is not an unknown factor in our law-making assemblies, but it is not from this class of men that we are to expect such legislative measures as will lead to reform in our local government. We need men of Mr. Erichsen's type, who are able to take a broad grasp upon those interest which so materially affect the public through the practice of medicine and through the want of adequate sanitary

knowledge. It is not the party politician that is needed, but the physician who can worthily represent the great educational and scientific interests of the people. Is it utopian to hope for the promotion of such men to our legislative assemblies, municipal, state and national? We think not. As a profession we are capable of wielding a large influence in politics, and if this influence is exercised in the right direction we may confidently expect to see our profession more ably represented in law-making bodies than is the case at the present time.

Albuminuria in the Apparently Healthy.—Since the examintion of the urine has become general a number of cases have been reported of albuminuria without other signs of kidney trouble. Many of these cases have come from examiners of life insurance companies. A man engaged in active life applies for life insurance and is astonished at being told that the company cannot accept him because he has albumen in his urine. Such cases may continue to show albuminuria for years, but otherwise be perfectly healthy. It is obvious, then, that it is a matter of great importance for the physician to be able to diagnoticate between this apparently harmless albuminuria and that which means serious organic disease of the kidney. The *London Medical Times and Gazette* of October 17, 1885, contains an article from F. M. Pavy, M. D., F. R. S., entitled "Cyclic Albuminura." Speaking of the class of cases which we have endeavored to describe, Dr. Pavy says: "I have observed in them a character which has served as a ground of distinction, (*i. e.* from Bright's Disease) and enabled me to express an opinion at the commencement which has been verified by the advance of time. The character I refer to is the *diurnal alteration* that takes place in the condition of the urine. Examined at one period of the twenty-four hours, the urine is found to contain, it may be, a large amount of albumen, whilst at other periods there is none, and what is observed one day is reported with more or less closeness the next. These cases thus have a *cyclic* character belonging to them, and hence my adoption of the term cyclic albuminuria. * * * In the early morning the urine is free from albumen. Albumen then shows itself at 9, 10 or 11 A. M., or not till the early part of the afternoon. After reaching its maximum it declines, and often by the evening it has disappeared. There may be considerable variation in the amount of albumen observed on different days. The condition noticed may go on not only for weeks and months, but even for years. It is not accompanied with any impairment of health, and there are none of the ordinary constitutional indications of the existence of Bright's disease present. In some cases I have noticed there has been a *sharp and unduly forcible cardiac* impulse, but the *pulse* has been soft, and not hard and sustained as in Bright's disease. "No casts of tubules are to be observed, but frequently oxalate of lime crystals are present." He then gives several cases, a synopsis of some of which follows: A man 21 years of age, of good health, chemist by occupation, discovered by his own examination with heat and nitric acid that his urine was albuminous. The examination was made "during a temporary attack of lumbar pain." Dr. Pavy found the urine passed on rising in the morning free from albumen. Between 10 A. M. and 2 P. M. "albumen began to be perceptible," increased till the maximum was reached at 6 P. M., afterwards declined and had disappeared at bed time. No casts were found, nor was there any constitutional evidence of Bright's disease. This was in the Spring of 1881. In March of the present year Dr. Pavy again examined the urine, and found that "the old condition still existed." From 1881 to 1885 the patient had "good bodily health in every way."

A second case was seen in November, 1881. The morning urine was non albuminous; "soon after after breakfast albumen began to be perceptible, and a little latter on was more evident." Usually it had disappeared by bed-time. "In March, 1882, the condition of the urine was the same. There was no sign of any impairment of health." In De-

cember, 1883, there was an absence of albumen.

A third case showed a trace of albumen in the first urine passed after rising. At other times the morning urine was free from albumen, but albumen was found in the urine passed after "a hearty meal," and "after a few games of lawn-tennis." Several other cases are given by Dr. Pavy, but these will suffice.

The causes of this intermittent albuminuria are, for the most part, uncertain. Senator is quoted in the *Philadelphia Medical News* of February 10, 1883, as follows: "Recent observation has shown that during digestion the excretion of albumen has been increased in those in whom albuminuria is present, has returned in those from whom it has disappeared; while the *digestion of a full meal* has even caused a transitory albuminuria in those who are otherwise free from it." In the issue of the same Journal for June 14, 1884, is found a carefully prepared paper on the subject by Dr. Casper Griswold, read before the New York County Medical Association. Dr. Griswold mentions, as causes of transient albuminuria, amæmia, prolonged and violent exercise, the presence in the system, in excess, of certain substances (as the biliary principles or iodid. potass.), imperfect digestion of albuminous foods, hysteria, mental anxiety, etc. He attributes most of the cases of transient albuminuria to a "*renal inadequacy*" brought about by some temporary functional disturbance which passes off without treatment.

Reviews, Books and Pamphlets.

Practical Surgery. By J. Ewing Mears, M. D., Lecturer on Practical Surgery and Demonstrator of Surgery in Jefferson Medical College, Philadelphia, etc, Philadelphia: P. Blakiston, Son & Co., 1885. Pp. 783.

This work first appeared in 1878, and perhaps is familiar to most students of surgery. It appears now so revised and enlarged as to keep up with the progress of surgery in its latest aspects. The work treats only of surgical dressings, bandaging, fractures, dislocations, ligature of arteries, amputations and excisions of bones and joints. Under chapters devoted to each of the foregoing subjects, the author has related his own experience as a teacher and practitioner, and has attempted to give the student a text-book which presents his subject matter in a concise manner and well-arranged form. The volume is illustrated with four hundred and ninety wood cuts, which portray the various instruments, operations and subjects treated.

An Atlas of Clinical Microscopy. By Alexander Peyer, M. D., Translated and Edited by Alfred C. Girard, M. D., Assistant Surgeon, U. S. Army. First American, from the Manuscript of the Second German Edition, with Additions. Ninety Plates, with One Hundred and Five Illustrations, Chromo-Lithographs. New York: D. Appleton & Co., 1885. Pp. 194.

To those students and practitioners of medicine who are interested in misroscopical work and who are familiar with the use of this valuable aid to human vision in the study of nature, the present work will prove of incalculable value, since it represents the original work of an accomplished microscopist and artist. The work is intended principally as a microscopical atlas arranged in parts as follows: Microscopic Examination of the Blood, Mammary Secretion, Urine, Sputum, Intestinal Contents, Contents of Stomach, Fluid Contents of the Various Abdominal Tumors, Secretions of Female Sexual Organs, and Various Micro-Organism Provoking Disease. Under each of these headings are arranged a number of plates showing the different microscopical appearances of the tissues and fluids examined. Accompanying the plates is a text of explanatory notes showing the various methods of of working with the microscope and the significance of what is observed. The plates have been most handsomely printed. We have seen nothing in this special line of study that will compare in point of accuracy of detail and artistic effect to the work under consideration.

Intestinal Obstruction. By Frederick Treves, F. R. C. S. Philadelphia: Lea Brothers & Co. 1885

We would show a great want of appreciation of good medical liturature, should we let pass the opportunity to notice the recent appearance of this most excellent little volume on such a very important and interesting subject; the importance of which the author so forcibly impresses upon us by telling us "that it is estimated that over two thousand individuals die every year in England alone from various forms of obstruction of the bowels, exclusive of hernia." While both time and space forbid our giving anything like the review that both the volume and subject demand, yet we will try to contribute our mite to the large share of credit which it deserves.

The author's classification of the subject upon "pathological grounds rather than upon clinical distinctions," is of decided advantage, we think, in the present meagre state of our knowledge of the correct clinical conditions in such cases. He, however, admits the great desirability of a purely clinical classification, and has given considerable aid to the attainment of that end, by the most excellent chapters he has devoted to diagnosis. In his chapter on the etiology of intestinal obstructions he takes broad and comprehensive grounds without wearying his reader with the many possibilities that may and do enter into its causation. He enumerates as the principle factors entering into the etiology, "peritonitis, strangulated hernia, and mesenteric gland disease." And in subsequent chapters he discusses thoroughly the various forms that occur under these special headings. He shows us very clearly the likelihood of intestinal obstruction to occur after attacks of peritonitis, by the bands that form and the adhesions that result, and explains very thoroughly the many modes of operation of such causes. Especially would he have us remember the dangers that are likely to follow the liberation of a gut from a strangulated hernia, when we are apt to consider our patient out of danger. These dangers are likely to follow both from immediate and remote causes. Among the former he includes the likelihood of the bowel to remain so entirely paralysed after reduction as to continue the symptoms of obstruction until death ensues, and that too without becoming gangrenous, or causing peritonitis. Of the remote causes he alludes to the peritonitis, which nearly always occurs in the previously strangulated loop of bowel, as likely to cause agglutination of their sides while in an acutely bent position, thus producing permanent knuckling and obliteration of the lumen of the bowel; also to the adhesions the bowel is likely to form with the abdominal parietes, or other organs as a result of the same peritonitis in the injured loop of bowel, and by a change in their relative position produce kinking as a result of the traction and permanent obstruction. Such causes of obstruction are also likely to follow ovariotomy where the adhesion takes place between the pedicle and the bowel, and upon the subsequent retraction of the pedicle produce similar results.

He cites several instances of the mode of operation of mesenteric gland disease in the production of intestinal obstruction. The chapter on volvulus is very clear and comprehensive, giving as by far its most frequent location, the sigmoid flexure. He says "if all the cases of volvulus of the intestine be considered collectively, it will be found that about two-thirds of the number are instances of twist of the sigmoid flexure about its mesenteric axis." In the chapter on the etiology of Intussusception he furnishes convincing proof of its dependence upon irregular action in the muscular coat of the bowel. Among the evidence he furnishes to corroborate this view are the vivisection experiments of Nothnagle, which carry conviction with them. In speaking of the treatment, he advocates a trial of the remedies usually recommended in such cases, such as, metallic mercury, massage, electricity, insufflations, enemata, and lastly opium, to which he gives the principle place among remedial measures, but reminds us that while of great value in relieving the more urgent and distressing symptoms, it must also be remembered that its use

may seriously interfere with the diagnosis in obscure cases of acute intestinal obstruction. He says: "It may so modify the symptoms and so affect the general aspect of the case that the more characteristic manifestations of the malady may be put entirely in abeyance." He, therefore, thinks that in acute cases the use of opium should be conducted with the greatest caution before a definite diagnosis has been made, or a specific plan of treatment has been decided upon. After a fair but brief trial of the above named remedies, together with some others that he mentions, he then urges the performance of laparotomy in the following forcible and decided language. "I would urge that laparotomy should be performed as soon as the diagnosis is fairly clear, and if possible within the first twenty-four hours after the appearance of the symptoms." "The operation is usually regarded as a last resource, it should be the first resource, especially as it is the only resource. Moreover in cases of doubt all recent experience in abdominal surgery would speak in favor of an exploratory incision. A simple cut into the peritoneal cavity, made with proper caution cannot be so calamitous a circumstance as an unreduced strangulation, or even a case of intestinal obstruction treated absolutely in the dark. An examination of the recorded cases shows very clearly that in proper instances, and especially in those where the operation is undertaken early enough, laparotomy is by no means so very fatal a proceedure. The one great fact that effects the issue of the operation is not so much the age of the patient, nor the seat of obstruction, nor the period in the disease when the procedure was carried out, but the state of the gut; and since pathology can give us precise teaching upon this latter point, there is no reason why laparotomy should not be rescued from the somewhat ignominious position it now occupies in surgery. There is no reason why in the future, with a fuller knowledge of the technical details essential to the operation, with a surer acquaintance with the clinical aspects of obstruction, and with the exercise of a sounder judgment in the selection of cases, the procedure of laparotomy should not have a mortality but little higher than that of the operation for the relief of strangulated hernia." We would most cheerfully recommend the careful perusal of this little work by the profession generally, and think it will well repay them for the time they bestow upon it. S. T. E.

Miscellany.

An Injustice to Dr. J. S. Billings.—The Washington correspondent to the *New York Medical Journal* writes: "Much sympathy is felt with Surgeon Billings on account of the recent ruling of the accounting officers of the Treasury Department whereby he is obliged to pay from his own pocket the expenses of his trip to Europe in attendance upon the meeting of the International Medical Congress and in collection of books and pictures for the library. This trip was evidently, as is reported, mainly for the latter purpose, and its results are already manifest in valuable additions to the library. Furthermore, the journey was made under the orders of the Secretary of War. It is understood that a similar ruling will be made on the traveling-expense accounts of Medical Director Brown, of the navy, who attended the same congress. The immediate effect of this ruling will be that these details will not be sought after as in the past. It looks to an unprejudiced observer as if medical men scarcely had an equal chance with other classes of our fellow-countrymen. An army officer of good looks, a graduate of the military free academy, and of undoubted pedigree, can with little trouble get an order taking him to witness the spring manœuvres at Saint Cyr, the mobilization of the *Landwher*, or perhaps the actual hostilities between contending forces, but who ever heard of an order detailing a doctor to witness the establishment and hygienic management of the hospitals abroad, or of the quarantine service? It is only recently that we have gained enough in that direction to allow of the sending of an expert to study the cholera epidemic, and one to participate in the sanitary conference."

Tubercular Meningitis Cured by Iodoform.—A Sweedish physician, Dr. Emil Nilsson, alleges that he has cured an undoubted case of tubercular meningitis by frictions on the shaved scalp with iodoform ointment (1 to 10). The patient was a boy, aged 8, whose mother had a family history of phthisis, and four of whose brothers and sisters had died from tubercular meningitis. The symtoms in this child's case were similar to theirs—headache, torpor, convulsions, strabismus, and pyrexia. He was at first treated with calomel and iodide of potassium, but did not improve; and, after having been under treatment a week, became distinctly worse, being unable to take food or medicine. The pallor of the face, which had preëxisted, gave way to flushes of the cheeks. The child threw himself out of bed, and presented severe clonic spasms of the limbs and of the facial muscles. The head was then shaved, and iodoform ointment rubbed in, an oil-skin cap being put on. The friction was repeated three or four times in the day, and the next day there was a decrease in the convulsive movements, the sleep was calmer, and spasmodic contractions, which had previously been excited by the slightest noise, now ceased to be so. Consciousness shortly afterward returned, and the child's face became of a more natural color. This, however, was accompanied by a severe coryza, redness of the lips, and irritable cough, the breath smelling strongly of iodoform. The ointment was discontinued, and syrup of iodide of iron given. The unpleasant symptoms rapidly disappeared, and the child was soon running about in good health.—*British Medical Journal*, November 21, 1885.

International Congress.–Special Announcement.—The Executive committee of the Ninth International Medical Congress, to be held in the City of Washington, D. C., commencing on the first Monday in September, 1887, having accepted, under rule 10 of the Committee on Preliminary Organization, the charge of the business of the Congress, hereby give notice to the members of the medical profession that they have been actively engaged upon, and have now nearly completed the arrangements for this meeting; and they anticipate the hearty coöperation of the profession everywhere in developing this great scientific and humanitarian assembly.

By order of the Executive Committee.

Henry H. Smith, M. D., Phila.,
Chairman of Executive Committee.

Nathan S. Davis, M. D., LL. D.,
Secretary-General of Ninth Int. Med. Congress.

A Cotton Reel Seven Years in the Vagina.—Professor Breisky gives an account in the *Prager Medinische Wochenshrift* of the case of a woman, who for seven years had suffered severe pain during menstruation, and, four years previously, had had an abscess in the inguinal region, which, on being opened, was found to contain a large quantity of pus. On examination, the vaginal mucous membrane was found greatly swollen, and the vagina itself seemed to come to an abrupt termination, no uterus being felt. On examination *per rectum*, a foreign body was made out, lying in a fluctuating sac behind the uterus, which was then felt displaced backwards. The patient, on being questioned, remembered introducing a cotton-reel seven years before. Under an anæsthetic, the vagina which was so contacted by cicatrix as only to admit a probe at one spot, was dilated, and the reel drawn out. It was 1.35 inches long, 1.15 inches in breadth. The contracted cicatricial portion of the vagina was kept distended, and some incisions made in it. The monthly periods became quite painless, and the patient made a good recovery.—*Brit. Med. Jl.*, Nov. 14, 1885.

Medical Items.

The Philadelphia Polyclinic has met with such encouragement that it will shortly move its quarters to a new building on Broad Street. The new building will contain larger hospital and dispensary accommodation than the present quarters at Thirteenth and Locust Streets.

The *Medical Record* states that at the recent election in England, eleven cities elected medical men as mayors.

Dr. Jenifer Garnett, a prominent member of the medical profession, of Richmond, Va., died recently at his residence in that city.

An Association has been formed in New York City, which has for one of its objects the "maintenance of the law of purity as equally binding upon men and women."

We have just learned of the death of Dr. N. E. Richmond, which occurred on June 27th last, at his home in Rose Hill, Lee County, Va. Dr. Richmond was a graduate of the University of Maryland, class of 1883.

Dr. E. R. Walker has been elected to the chair of Pathology and Clinical Surgery, and Dr. S. K. Merrick, of this city, has been elected to the chair of Diseases of the Throat and Chest in the Baltimore Medical College.

Chicago is to have a Polyclinic Society. On November 20th, a number of Physicians met and organized a school. Dr. W. T. Coleman, formerly of this city and connected with the Baltimore Polyclinic, was elected Vice-President.

The smallpox epidemic is rapidly diminishing in Montreal, principally because it is burning itself out, and partly, owing to the vigorous efforts of the Board of Health, during the last month, in enforcing either removal to hospital or isolation.

The Minister of the Interior has written to the Academie de Médicine, that he places at the disposal of that body a sum of 2,000 francs (£80) annually, to be awarded to the writers of the best works on the mortality of new-born children.

Dr. Squibb suggests as a means of disguising the taste of bitter and nauseous salines, a mouthful of icewater just before and just after the dose; the saline itself to be taken in a wine-glass of ice water between them.—*Boston Med. and Surg. Jl.*

A physician was fined at Oswego, last week, $250, with the alternative of six months' imprisonment, for contempt to court in refusing to testify in a criminal case. He pleaded, unwillingly, as a defence that his testimony would involve the disclosure of professional secrets.—*Medical News*, December 5th.

The authorities of Saragossa have voted to grant an annual pension of I,500 pesetas (about $300) to the family of every physician who died of cholera while in the discharge of his professional duties; and the hope is expressed that the officials of other cities and provinces will imitate their example.—*Medical Record.*

The Rappahannock Medical Society is the title of the Society organized in Fredericksburg, Va., during October, with the following officers for the ensuing year: *President*, Dr. S. W. Carmichael, of Fredericksburg, Va.; *Vice-President*, Dr. A. J. Chandler; *Recording Secretary and Treasurer*, Dr. P. S. Ray. The regular meetings are to be on the first Saturday of each month, and at each quarterly meeting some medical subjects shall be discussed. "Typho-Malarial Fever" is the subject appointed for discussion at the January, 1886, meeting.— *Va. Med. Monthly.*

At a meeting of the Medico-Legal Society, held November 18, Prof. R. Ogden Doremus reported what he believed to be a case of fatal poisoning from the application of cocaine to an aching tooth. Dr. F. D. Thomas, a graduate of Bellevue College, had written him an account of the case, in which he found the patient, a woman, unconscious and dying from the effects of a medicine which she had been using for toothache. He also sent on to New York what was left of the drug, and on examination, it had proved to be hydro-chlorate of cocaine. A general discussion of the effects of the remedy followed.—*Boston Med. and Surg. Jl.*

Original Articles.

TETANUS FOLLOWING ABORTION.*

BY JOHN MORRIS, M. D., OF BALTIMORE.

This is a subject that has not been discussed in American literature. My attention was particularly called to it by a case which occurred in the Criminal Court of Baltimore in October last. A certain "Voodou" doctor, named Snowden, was tried for murder on the 4th of that month. The testimony showed that an abortion had been produced but that the woman had died of tetanus. Dr. Albert B. Lyman, who gave a certificate of death from *tetanus*, testified that the death was not indirectly caused by the miscarriage, as that could not be an exciting cause of tetanus. The other medical witnesses in the case, Drs. Walker and Urquhart, did not concur with Dr. Lyman, but thought the patient's death was due to puerperal convulsions.

Owing to the nature of this testimony the "Voodou" doctor was acquitted of the charge of murder; but on the next day was tried upon another indictment, that of producing abortion, and I was summoned as an expert witness on behalf of the State. All the evidence pointed to the fact that an abortion had been produced and the defendant was found guilty of the charge. I met Drs. Lyman and Walker and expressed some surprise to them that in the trial for murder the day before tetanus had not been recognized as a consequence of abortion. Dr. Lyman said he had examined all of the authorities and found nothing bearing on the subject. I promised to write him and give him some facts referring to this matter. I wrote him the next day the following letter:

DEAR DR. LYMAN.—I write you a line, as I promised, concerning tetanus in cases of abortion.

The literature of the subject is very abundant. A quarto volume was written on it in 1878 by Collongues, entitled, "Contribution a l'etude du tétanos puerperal consécutif à l'avortement," 4 mo., Paris, 1878.

You will also find a fatal case of tetanus supervening on abortion in the *Va. Medical Gazette*, 1857, another case in the *Medical Press and Circular*, 1870.

We have had several cases in our own city; one has been reported by Dr. Neff in the MARYLAND MEDICAL JOURNAL, September 8, 1883, page 296. Dr. McShane, Assistant Health Commissioner, tells me that he had a case in his practice which terminated fatally on the third day, and Prof. Erich had also a case which ended in death. You will find by reference to the MARYLAND MEDICAL JOURNAL, July 8, 1883, the subject discussed by myself, I add the quotation:

TETANUS IN LABOR. Dr. Morris made the following remarks upon this subject.

"At a recent meeting of the Association Dr. Neff related a case of tetanus following labor, which the Doctor supposed was unique in character. Since that time a similar case has been reported in the *British Medical Journal*. The patient died three weeks after her confinement. Puerperal tetanus is not a frequent trouble in this country; it is more apt to occur after abortions than after labor at full term. It is believed to be climatic in its origin, at least Dr. Playfair thinks so. He says that its occurrence is not rarer than after surgical operations. In countries in which tetanus is common, as in India, for instance, it is far from being a rare event. You will also find a case of puerperal tetanus in the MARYLAND MEDICAL JOURNAL, Vol. IX, page 625. I could cite many more instances, but these are sufficient."

Dr. Lyman replied as follows:

BALTIMORE, Oct. 9, 1885.

DEAR DR. MORRIS.—I am extremely obliged to you for your very kind letter. That *tetanus* was one of the sequels of labor, whether premature, or at full term, was a fact which had not hitherto come to my knowledge. In looking over the "*Contents*" Playfair, Leishman, Meadows, Ramsbotham, Jewell, Murphy, Lee, and Denman, which I have in my

*Read before the Gynecological and Obstetrical Society of Baltimore, December 8, 1885.

obstetrical collection, I do not find *tetanus* even mentioned, nor was reference ever made to it by Dr. Graily-Hewitt, whose lectures on Midwifery I attended for two years, nor was the subject ever alluded to at the Rotunda, where, I believe, we both acquired a certain amount of our information about obstetrics.

At the Coroner's inquest there was some conflict of medical testimony, Dr. Urquhart giving as his opinion that it was a case, not of *tetanus*, but of *puerperal convulsions*. In this view Dr. Walker coincided, and I understood from him that previously to your bringing the matter to his notice, he had not heard of a case of *tetanus* resulting from *abortion*. I believe this was the reason why they both considered it a case of *eclampsia*. Since, however, I was satisfied of its being *tetanus*, I adhered to that view, and regarded it as *idiopathic*, in the absence of any apparent exciting cause.

As stated above, I had found no reference to *tetanus* in the standard works on *Obstetrics*, from which I had acquired my information in addition to that I had learned in London from Dr. Graily-Hewitt, and in Dublin from Drs. Johnston, Churchill, Macan and Purefoy. It would seem, therefore, that a grave omission exists in the recognized text-books, relative to this matter. In the light of what you have said, it appears very much as though I was right in my diagnosis of *tetanas*, and that Drs. Urquhart and Walker were wrong in thinking otherwise, whilst, at the same time, I was wrong in expressing the opinion that inasmuch as it was *tetanus* the death was not indirectly caused by the miscarriage, as not being a cause of *tetanus*.

It is to be hoped that, thanks to your kind and courteous account, we shall all know better next time.

I should very much like to hear the views of Dr. T. H. Buckler, and would suggest having your letter to me, and this one, submitted to him, for the purpose of endeavoring to trace the pathology of *tetanus* resulting from *abortion*. He would, doubtless, take much interest in it, being himself a most expert obstetrician and a man of unusual attainments in medical science.

Very truly yours,

A. B. Lyman.

59 St. Paul Avenue.

In addition to the authorities cited in my brief note to Dr. Lyman, I find the following contributions to the subject in the different Journals quoted: Boyd, *Dublin Journal Medical Science*, 1874; Fearon, *Medical Press and Circular*, 1870; Hæpffner, *Gazette Medical de Strasburg*, 1874. This case which proved fatal was marked by an extraordinary rise in temperature. In twenty-four hours it rose from 37.8° to 42 5° C. Thompson and Maclay, *Philadelphia Medical and Surgical Reporter*, 1867, report a case of tetanus following abortion, and there is also a paper to be found in the *Medical Journal of the Netherlands* by Baart de la Faille entitled, *Tetanus Post Abortum*.

All the cases given above present a marked similarity in the symptoms as well as the course of the disease.

Dr. Banga, of Chicago, reports in the *American Journal of Obstetrics*, 1879, a fatal case of tetanus following retention of a segment of the placenta after abortion. A post-mortem was made and no lesions discovered save a slight projection on the anterior wall of the uterus near the opening of the right tube. This projection was the size of a nickel, and presented the appearance of a remnant of placenta.

Dr. Banga believes that retention of portions of the placenta can account for tetanus. He says that the condition of the uterus in abortions of this kind must be regarded as analogous to any wound undergoing the healing process. Thus, any complication which may disturb the healing process of a wound in some other part of the body, may also occur in connection with the involution of the uterus and the restoration of its lining membrane after the expulsion of a fœtus. He says that the resemblance between the tetanus occurring in the course of a case of abortion in which a segment of placenta is retained and the tetanus as a complication of some other wound, seems

the more obvious, since it is universally accepted by surgeons that tetanus is most likely to supervene in wounds in which a foreign body maintains that peculiar, though still unknown, irritation to the nervous system which results in tonic spasms.

This is no doubt the correct view. Tetanus after ovariotomy is not uncommon and can be readily accounted for on the hypothesis of Dr. Banga. Dr. Gaillard Thomas mentions a case of tetanus following the introduction of a sponge tent for the removal of a placenta. Fortunately this accident is not very common, though its etiology may be easily explained in view of the facts already presented.

The treatment in these cases is neces sarily very simple. The patient must be kept quiet and chloral administered in proper doses by the rectum. Food must also be given in the same manner. Hypodermic injections of morphia will be found extremely useful and may be employed from time to time with marked benefit. Galvanism can also be used in many cases with advantage. The prognosis is nearly always serious in cases of tetanus after labor and the practitioner who is unfortunate enough to meet with a case must from the beginning realize the gravity of the situation and be extremely guarded in any judgment he may express concerning its termination.

Clinical Lectures.

SPASM OF THE SPHINCTER ANI AND ITS TREATMENT BY FORCIBLE DILATATION.*

A CLINICAL LECTURE† BY T. PRIDGIN TEALE, M. A., OXON., F.R.C.S.

"If a patient complains of piles, the chances are three to one that it is not piles from which he is suffering." Such are the words with which it has been my custom to commence a clinical lecture on affections of the rectum and anus.

To this let me add a second statement. "There is hardly any affection of the anus or lower end of the rectum in which spasm or hypertrophy, or irritability of the sphincter ani, does not play an important and leading part, either as the main cause of suffering, or as a secondary complicating factor with which the surgeon has to reckon if he is to command a thoroughly satisfactory result." In other words, in any complaint of "piles," though hæmorrhoids may be absent, there will be, almost invariably, an irritable or hypertrophied sphincter, which must be set at rest if the patient is to be cured.

To these two statements may be added a third. "During the last 20 years I have only once used the knife for the cure of fissure of the anus, or of spasm of the sphincter ani. In every other instance I have used 'forcible dilatation.'"

In surgical works dealing with affections of the rectum and anus the sphincter is referred to rather as playing a subordinate or accidental part, nay sometimes is entirely ignored. In this lecture I wish to lay stress on the fact that the sphincter ani is nearly always an important and is very frequently the leading factor in rectal ailments, and to tie together a series of such ailments by this common bond of their dependence on a disturbed sphincter.

In so doing, I have somewhat narrowed the scope of my lecture. In fact, one of my colleagues wondered how I should manage to fill up the time with such a slender theme. And yet what a large share in the troubles of humanity do sphincters take, and how much of surgical attention do they command; nay, what an increasing attention, since of late years dilatation has filtered more and more into the surgical mind to the suppression in some instances of treatment by the knife! Do we not dilate the neck of the bladder, not only for diagnostic, but also for curative purposes, both in the male and in the female? Do we not dilate the os uteri internum in hæmorrhages and in some forms of endometritis? Do we not sometimes treat vaginismus by dilatation of the sphincter vaginæ? And, if I may digress from

*One of a series by the Consulting Staff of the Leeds Infirmary. Session 1884–5.

†From the *London Medical Times*, Nov. 28, 1885.

sphincters strictly so-called, do we no treat spasmodic strictures of the circular fibres of the œsophagus by dilatation by bougies? The medical man, be he physician or surgeon, or family attendant, who has learned to appreciate the degree in which perverted action of the sphincters can disturb the balance of the healthy working of the cavities which they command, has acquired the key to a very numerous class of bodily ills and discomforts.

As the type of perverted sphincteric action, let us take the instance of "fissure of the anus." Commencing, perhaps, in a slight tear or scratch of the mucous membrane, just within the grip of the sphincter, it is continued as an abrasion, or a clack, or a fissure, or even as a definitely excavated ulcer. Becoming irritable and painful, and suffering from the grip of the sphincter, the ulcer acts upon the sphincter, provoking it to spasm, and in time induces even hypertrophy. Meanwhile, the strangling grasp of the sphincter reacts upon the raw surface, and deprives it of the physiological rest needful for its recovery. Surgery has recognized the mutual interdependence of a sore within the anus and irritability of the sphincter, and has perceived a two-fold line of treatment. "Heal the sore, and the irritability of the sphincter will cease," "destroy the undue activity of the sphincter, and the sore will heal." Attempts to cure the sore by soothing and caustic applications have often been made, sometimes with success. Failing such local remedies, the surgeon attacks the sphincter itself, and by division of more or less of its fibres sets it at rest and cures the disease. Such was the standard method of dealing with the sphincter ani for the cure of fissure in my student days and during the earlier years of my professional life, and I believe it lingers as the orthordox treatment in the minds of some of our surgeons. It is now some twenty years or more since I first heard of the then new method of forcible dilatation of the sphincter ani as a substitute for division by the knife. Brought out in Paris by, I believe, M. Verneuil, it was introduced into this district by Mr. Jonathan Hutchinson, who, when meeting my father in consultation, suggested and performed dilatation as a substitute for the knife. From that time my father abandoned the knife, and I followed his example.

This introduction of forcible dilatation has proved an inestimable boon to surgery. In the first place it has introduced a more exact and, as it seems to me, a more scientific method of dealing with the variable conditions of sphincter which are found in such cases. The educated dilating fingers of the surgeon have a far better consciousness of the amount of resistance to be overcome, and of the degree of the relaxation to be demanded and attained, than can be attained in using the knife. Failure to cure is, in my experience, and I believe in the experience of my colleagues, extremely rare. The main object aimed at is attained far more effectively and satisfactorily by the use of the fingers than by the knife or even by the three-branched dilator. There are, indeed, rare instances in muscular men in which a mechanical dilator, such as the ordinary three-branched dilator of the female urethra (Weiss), or a special short-branched modification of it devised by my colleague Mr. Jessop, is of use when the power of the surgeon's fingers or thumbs proves insufficient for the purpose.

But it is not in fissure alone that this beneficial result of dilatation is to be found. We have learnt to appreciate its value as an aid in other operations.

I have spoken of "fissure" as a cause of spasm, in which there can be detected by the finger an actual breach of surface of mucous membrane, be it in the form of abrasion, crack, or ulcer. There is, however, a class of cases in which, without such tangible reason, the sphincter is too powerful, resisting the introduction of the surgeon's finger, and is the cause of habitual constipation, long delay at the water-closet, retention of flatus in the colon, and colicky pains in the left loin. Such pains are often attributed to disturbances of the kidney or to rheumatism. Whenever a patient has pain in the left lumbar region, accompanied by constipation and tedious visits to the water-closet, and above all, if there are

occasional streaks of blood on the evacuations, suspect spasm of the sphincter and examine the anal aperture with the finger.

A third class of cases is most deceptive and may easily escape detection. There are present some of the symptoms of fissure, obstinate constipation, colicky pains in the loin, and great difficulty and pain in defœcation, and yet examination of the anus discloses neither fissure nor ulcer, nor spasm of sphincter. Should, however, the surgeon, relying upon the presence of the general symptoms of a tight sphincter, determine to test the point by examination under ether, he will find, on introducing the forefinger of each hand, that the sphincter yields readily, *up to a certain point*, just sufficient perhaps to admit the two fingers, and to allow the escape of a soft or a solid evacuation of small calibre, but that beyond this it is absolutely rigid, like a ring of cartilage, far more unyielding than the ordinary sphincter in fissure, and needing all the power of, sometimes proving almost too much for, the surgeon's fingers to break through.

Another class of cases in which dilatation of the sphincter proves of great value is to be found in *slight internal bleeding piles*, which may often be cured thereby. This fact was first taught to me by my father some twenty yeare ago, when, in accordance with his suggestion, I cured, by forcible stretching of the sphincter alone, a gentleman who was suffering from considerable hæmorrhage from internal piles. My father probably deduced the principle of treating bleeding piles by reducing the power of the sphincter from the late Professor Syme, substituting dilatation for the incision recommended by Syme. Professor Syme, in his "Observations on Clinical Surgery," p. 85, under the heading Hæmorrhage from the Rectum, says:—"Another source of hæmorrhage from the rectum, which could not have been readily anticipated, is spasmodic stricture of the anus. The fissures and ulcers which are so frequently connected with this condition usually discharge a little blood, although hardly so much as to constitute a prominent feature in the case; but, independently of any such complication, a mere contracted state of the sphincter may occasion the most profuse and serious bleeding." In a case related "I found that the external part of the sphincter was tightly contracted, and, knowing that this might be the cause of the bleeding, I made a division of the tight muscular fibres. No blood was subsequently discharged, and the patient soon regained his healthy aspect." From that time it has been my practice to treat moderate hæmorrhoids by dilatation in the first instance reserving further operation by ligature for those cases (a small minority) in which mere dilatation did not prove adequate.

Let us enquire what has been the history of this question:—

In 1877 M. Verneuil, the originator of dilatation, brought the subject of the cure of hæmorrhoids by dilatation before the Surgical Society of Paris, and was supported by hardly a single speaker, many of those who spoke betraying the most profound ignorance of the subject and a complete inability to grasp the principles of dilatation.

Mr. Bryant, in the last edition of his work on Surgery, published so recently as 1884, after condemning "forcible dilatation, as practised abroad, as a barbarous treatment," speaks of this method of treating internal piles as follows:—"In Paris a plan of treatment has been successful which claims attention, as it receives the support of M. Verneuil," but he does not seem either to have used it or to approve of it.

Mr. Allingham, in his work on the rectum, published in 1882, describes more fully the views of M. Verneuil and M. Fenton, both of whom arrived independently at the same conclusions about the sphincter and its relation to hæmorrhoids.

Leaving now the cases in which dilatation of the sphincter is the sole or chief means of cure, let us consider other cases in which it becomes a very important accessory to treatment.

First and foremost in any removal of piles, whether by ligature, cautery, or nitric acid, undoubtedly the first step to be taken by the surgeon should be to pro-

duce thorough relaxation of the sphincter by forcible stretching.

Much is gained thereby. In the first place internal piles, previously out of sight, within the anus, are brought to view, and are entirely at the command of the surgeon to work his will upon. In the second place by reducing for a time the power of the sphincter, the parts are set at rest during the earlier days of operation, when an untamed sphincter would be roused to abnormal activity, and severely grasp and worry the wounded bowel. In fact, we secure by dilatation greater facility for dealing with the bowels during the operations, and physiological rest in the early painful days which follow the operation.

Mr. Allingham (p. 134) says that in operating on piles "I gently, but completely, dilate the sphincter ani."

Contrast with this the old-fashioned plan of making a patient sit "for half-an-hour on a bidet over hot water," struggling to force his piles down through a recalcitrant sphincter, as a preparation for operation.

In another class of cases I have found dilatation of great value. Whenever, in deeply extended fistula, free division into the rectum would involve a risk of permanent incontinence of the anus, I have been enabled by dilatation of the sphincter to rest content with but partial slitting up of the fistulous sinus, and have found that the enforced quiescence of the sphincter has allowed the rectal end of the sinus to heal. In attempting this, it is necessary to make the skin opening large, like the base of a triangle of which the rectal end of the fistula forms the apex, care also being taken to vigorously scrape away all granular lining of the fistulous track by Lister's scraper or Volckman's spoon.

Again, dilatation sometimes enables us to pass the fingers or portion of the hand much higher up the rectum and thus to discover a stricture or cancer not otherwise to be detected by an ordinary digital examination.

Lastly, on two or three occasions moderate dilatation has proved to be of infinite value in children suffering from obstinate constipation resulting from soreness or cracks within or near the anus.

In one instance a child about three years old was brought to me on account of fæcal incontinence. The bowel seemed to be incessantly acting. On examination I found a sore at the anus, and the sphincter in painful spasm. Examined under an anæsthetic, the rectum proved to be loaded with a large soft fæcal mass, rigidly guarded by a resentful sphincter. Dilatation of the sphincter set free the mass, restored healthy action of the bowel, and cured the patient.

In conclusion let me state my belief—

(1) That spasm of the sphincter ani, as a cause of constipation, suffering and ill-health, is often overlooked, and patients are allowed to suffer for years who might be cured in five minutes.

(2) That spasm of the sphincter can be arrested by forcible dilatation more satisfactorily, more certainly, more scientifically, and with greater safety, than by division by the knife.

(3) That in all operations on the rectum and anus dilatation of the sphincter is an essential, almost an indispensable, element in the treatment.

Clinical Reports.

A CASE OF FRACTURE OF THE ANTERIOR SUPERIOR SPINE OF THE ILIUM.

Dr. Thos. C. Peebles, of Lutherville, Md., contributes the following:

G. P., a teamster of the Ashland Iron Company, while hauling three or four tons of iron-ore in a wagon, over a country road, met with the following accident: He was under the influence of liquor, and while going down a hill he was sitting on the lazy-board of the wagon and fell off in front of the back wheel, which must have passed over his right leg in the length of the limb from the pelvis to the foot. He was found lying on the road and carried home and put to bed.

I was called to see him next day and I found that he had been bleeding all night, as the bed was saturated with

blood. I could find no fracture of the thigh, leg or foot, but on the skin there was a broad red band extending from a little below the anterior superior spine of the ilium to just above the knee on the inside, and again from below the knee to the foot and across the instep. Four inches below the anterior superior spine of the ilium on the front of the thigh was a small wound from which the blood had come. On probing this a hard substance was felt. I at first thought it might be a piece of wood or some other foreign body driven into the flesh. Dr. J. Jarrett, of Towson, saw the case with me and we decided to cut down and remove the substance; so I enlarged the wound and took hold of the object with a pair of forceps to clean it out, when I found it was bone with muscle attached to it; in fact, it proved to be the anterior superior spinous process of the ilium itself with a portion of the crest; a triangular piece of bone, about two inches long and and one wide.

Now, I cannot satisfactorily explain how the wagon wheel carried the portion of bone down under the surface to the point indicated; nor, again, how such a heavy load could pass over a man's limb without doing more damage. It is true that the road was very muddy and the ruts were very deep.

He wore a pair of long cow-hide boots, which showed the track of the wheel, especially over the instep where the boot was very much mashed and cut.

The wound was washed with a solution of carbolic acid and the limb raised, but a large slough took place along the front of the thigh, and the patient's temperature rose to 105° and remained so for three days. Finally, he made a good recovery, and can cross his legs in spite of the loss of the superior attachment of his sartorius muscle.

A case of absolute blindness from amaurosis, due to non-essential or simple anæmia, has recently occurred in Berlin. After confinement to bed, a generous diet, and treatment with iodide of iron, the patient, a girl, aged 15, recovered.—*Br. Med. Jl.*

Society Reports.

BALTIMORE ACADEMY OF MEDICINE.

STATED MEETING HELD DEC. 1ST, 1885.

The President, DR. J. J. CHISOLM, in the chair.

After the regular order of business the following cases were related:

EVISCERATION OF EYE-BALL BY THE NEW METHOD.

Dr. J. J. Chisolm related a case of evisceration of the eye-ball after the plan recently recommended. The operation consists in completely excising the cornea by means of a circular incision around its margin. The contents of the ball are then to be entirely removed leaving the sclerotic in tact. The advantage claimed for the operation, is that the socket tissues are not disturbed, neither is the muscular apparatus of the eye interfered with; besides, the stump left, after cicatrization leaves an admirable seat upon which to locate the artificial eye. The operation itself is a very simple one and can be performed much more expeditiously than can complete enucleation, but convalescence is so very tedious, and, at times, gives rise to such painful and alarming symptoms, as occurred in his case, that in future he will confine himself to the old plan of complete enucleation.

Dr. Chisolm said that it was his usual custom to allow a patient to go about his affairs very soon after the operation, at the outside, twenty-four hours, but in the evisceration operation, even up to the fourth day and later, there was such œdema and pain that he could not think of allowing the patient to be from under his observation. He had never had such an experience with the old method.

Dr. S. C. Chew wished to know if sufficient anæsthesia could be produced by the use of cocaine, to enable one to perform

this operation without painful sensations on the part of the patient.

Dr. Chisolm thought not.

PARALYSIS THE RESULT OF A FALL.

Dr. A. B. Arnold related a case which occurred at Bay View Asylum a year ago. It occurred in a woman five months pregnant. She fell from the second story window, striking upon the head; when picked up she was senseless and remained so for three days. Among the consequences of the fall abortion was brought on. At present she has paralysis of both lower extremities, complete anæsthesia on right side, is deaf and, also, blind on this side.

She evidently has some spinal trouble, as she complains of that sensation so common to these troubles, "as if a belt were being drawn about her waist;" also has some enfeeblement of the sphincters of bladder and rectum. In addition there is a peculiar nervous jerking about the head, which has continued for one year.

Dr. Arnold thinks the lesion is located about the inferior third of the internal capsule, extending up and involving the optic and auditory nerves at their point of crossing, and also, does he take the nerves of sensation which come off at this point to be affected. He thinks the symptoms justify this conclusion. The pupils responded normally to light. She had never had any trouble previous to the fall.

Dr. Chisolm asked of any ophthalmoscopic examination had been made. He said he was prompted to ask this question by a case which recently came under his observation. It occurred in a man who had received a severe beating, and among the results, loss of vision began after about six weeks.

He examined him, and found anæsthesia of the fifth nerve, the hearing involved, and several small retinal hemorrhages around the point of entrance of the optic nerve.

Dr. S. C. Chew related an interesting

CASE OF EMPYEMA.

He had been called in consultation to see a case which occurred in a patient who for several days past had suffered from severe dyspnœa. The night before he saw the patient, he had had copious expectoration of matter, the nature of which he could not describe as it was not saved. This was followed by immediate relief from the difficulty of respiration.

Upon physical examination of the chest the left pleura was found to be about two thirds filled with fluid. Shortly after his visit, the patient suddenly died with profuse vomiting of purulent matter as well as the passage of quantities of it from the bowels. From such symptoms, he thinks it highly probable that perforation took place through the diaphram into the stomach and that the fluid was discharged in both directions, through the œsophagus and through the intestines. He had searched the literature on the subject and had found no case, terminating in this manner, recorded. Physical examination of chest made before the first expectoration of matter showed the pleural cavity to be entirely filled with fluid. More recently he had seen a patient at the Baltimore Infirmary whose physiognomy was indicative of pulmonary trouble. Percussion over right side of chest gave decided resonance both anteriorly and posteriorly. On auscultation on same side there was pronounced *Hippocratic Succussion.* Shaking the patient while ear was still on the chest gave a sound very similar to that heard when one shakes a jug partly filled with water. No discomfort at all was noticed, neither pain nor dyspnœa. He thought the absence of dyspnœa could be explained on the ground that the air probably distended the pleura (and this compressed the lung) so gradually that this lung as well as the healthy one had sufficient time to accustom themselves to their abnormal relations. Whether perforation was due to ulceration outward through the pleura, from the wall of a cavity in the lung or whether it was due to a loss of substance occasioned by a point of in-

flammation upon the visceral pleura and thus perforation taking place in the reverse direction, he could not say, although symptoms sufficiently marked were present to point to either mode.

In his opinion surgical interference should be resorted to as soon as the condition of empyema is made out.

Dr. Arnold had seen a case of empyema in a child. It occurred on the right side, ulcerated through the diaphragm, and discharged its contents into the abdominal cavity. The child died from shock. He considered it somewhat remarkable how rarely phthisical patients showed any signs of discomfort from interference with respiration, even though their lungs might be riddled with cavities.

Dr. Chew looked upon this as due to the slowness of the pathological process, this enabling that portion of the lung which is healthy to increase its physiological activity. He also thought, in view of the fact that cavities so frequently form near the pleura, that it was singular that we so rarely found perforations from them.

Dr. Chisolm said serous sacs resisted perforation.

THE COCAINE HABIT.

Dr. J. C. Thomas said since he had been told that in some of our principal cities the cocaine habit was largely being acquired, he would like to ask if any member had ever seen a case of it, and if the report is true, did not the gentlemen think that the medical profession should take some steps to prevent the the reckless prescription of this seductive drug.

Dr. Chisolm related two cases in which decided loquacity was produced by the introduction of cocaine into a cavity in a decayed tooth. In speaking of *cocaine tablets*, he referred to a condition amounting almost to a slough, that was produced on the buccal surface of his own cheek from the application of one of these tablets to the gum and allowing it to remain until dissolved. From this, he hardly considered them the thing to use in nasal catarrh.

Correspondence.

AUDI ALTERAM PARTEM; A CRITIC CORRECTED.

BALTIMORE, Dec. 14, 1885.

Editor Maryland Medical Journal.

DEAR SIR:—I have just seen in your issue of the 12th inst. a Card from *Dr. John R. Quinan*, in which he kindly takes me to task for a supposed *lapsus linguæ* in an off-hand discussion of Prof. Miltenberger's paper on "Version or High Forceps." Dr. Quinan alleges that I "depended too much on memory," and did "unintentional injustice" to his and my venerable preceptor, the late Prof. Charles D. Meigs. Indeed, Dr. Quinan is so impressed with the importance of my supposed *faux pas*, that he gallantly comes to the rescue of the reputation alike of Prof. Meigs and the Jefferson Medical College, upon both of which, he affirms, I have been guilty of an "unintentional reflection!" Dr. Quinan's motives are good. But what of his performance? Let us see.

In the remarks to which Dr. Quinan takes exception, I was endeavoring to show that in all pelvic presentations, whether natural or artificially made, the forceps are of great value, and the following is what he cites and criticizes:

"Dr. H. well remembered how vividly the late Prof. C. D. Meigs used to impress upon the Class at the Jefferson Medical College the importance in such cases of having the forceps at hand ready for use, by relating a case, which is recorded in his work on *Obstetrics, in which the child cried within the vagina, while his foreeps were sent for.* The head was speedily withdrawn when he received the instrument, *but too late to resuscitate the child.*"

Now, let us see what Prof. Meigs himself teaches in his work on *Obstetrics*, 5th Ed., and last, page 410.

"A few years ago I was engaged to attend a young woman in her first childbirth. When she fell in labor, I discovered that the breech presented. Her residence was about three-fourths of a mile from my house. I was very much inclined to send for my forceps for fear that when the head should come at last to occupy the vagina I might be unable speedily to deliver it, but as she was exceedingly delicate and timid, and her friends anxious, I deferred sending for them lest needless alarm should be the consequence of bringing them to the house.

The labor proceeded favorably until the shoulders were free, and, then, notwithstanding the

head took the most favorable position, I found no exortation or entreaties sufficient to make the woman bear down, and the child soon became threatened with asphyxia, which I obviated by admitting the air freely to its mouth and nostrils by pressing off the perineum, as before explained. *The child cried from within the vagina*, and I felt a hope that the forceps, which I now sent for, would arrive in time for its succor. The instruments were placed in my hands in the shortest time possible. In two minutes after I received them they were applied, and the head withdrawn, *but it was too late to resuscitate the child.* I have never since failed to order my forceps to be placed within my reach in any case of footling or breech labor, and I feel well assured that the consequence of this case has been the saving of several lives that must have been lost but for this precaution."

Comment would be superfluous. Dr. Quinan declares that "Dr. Wm. T. Howard did the memory of his and my venerable preceptor unintentional injustice by confounding the relation of one of Dr. Meigs' own cases with his relation or another's!"

I submit to every intelligent reader whether Dr. Quinan or myself has done "unintentional injustice" to the memory of Prof. Meigs by "confounding" his cases, and which of us best understood and most correctly remembers the teachings of "our common master."

During my pupilage, and for many years afterwards, I received many acts of courtesy and kindness from Professor Meigs, and no one can hold in more grateful and affectionate remembrance than I do his genial nature and illustrious name.

Very truly and respectfully yours,

W. T. HOWARD, M. D.,

181 Madison Avenue.

BOOKS AND PAMPHLETS RECEIVED.

The Physician's Visiting List. (Lindsay & Blakiston's) for 1886. Thirty-Fifth Year of its Publication. Philadelphia: P. Blakiston, Son & Co.

A Guide to the Practical Examination of Urine. For the Use of Physicians and Students. By JAMES TYSON, M D Fifth Edit on, Revised and Corrected. With Colored Plates and Wood Engravings. Philadelphia: P. Blakiston, Son & Co., 1886. Price $1.50.

Rectal Medication. By D. W. CATHELL, M. D. (Reprint from Transactions of the Medical and Chirurgical Faculty of Maryland, 1885.)

A Manual of Operative Surgery. By LEWIS A. STIMSON, B. A., M. D., etc. Second Edition. With 342 Illustrations. Philadelphia: Lea Brothers & Co. 1885.

The Physiological and Pathological Effects of the Use of Tobacco. By ROBERT ARMORY HARE, M. D. (University of Pennsylvania) B. Sc. Fiske Fund Prize Dissertation, No. XXXIV. Philadelphia: P. Blakiston, Son & Co. 1885.

Lectures on the Diseases of the Nose and Throat. Delivered during the Spring Session of Jefferson Medical College by CHARLES E. SAJOUS, M. D. Illustrated. Philadelphia: F. A. Davis, Att'y, Publisher. 1885.

The Metric System in Medicine. By LLEWELLYN ELIOT, M, D. Washington, D. C. (Reprint from Medical Record, October 17, 1885.)

A Manual of Microscopical Technology for Use in the Investigations of Medicine and Pathological Anatomy. By DR. CARL FRIEDLANDER, Berlin. Translated with the Express Permission of the Author from the Second Enlarged and Corrected Edition. By STEPHEN YATES HOWELL, M. A., M. D., Buffalo, N. Y. New York and London: G. P. Putnam's Sons. 1885.

Psychiatry; a Clinical Treatise on Diseases of the Fore-Brain. Based on a Study of its Structure, Function and Nutrition. By THEODOR MEYNERT, M. D., Vienna. Translated under Authority of the Author, by B. Sachs. M. D., Instructor in Diseases of the Mind and Nervous System in the New York Polyclinic. Part I. The Anotomy, Physiology, and Chemistry of the Brain. New York and London: G. P. Putnam's Sons. 1885.

Aids to Medicine. Part III. By C. E. ARMAND SEMPLE, B. A., M. B., Cantab., etc.—Aids to Gynæcology. By ALFRED S. GUBB, L. R. C. P., M. R. C. S., etc.—Aids to Surgery. By GEORGE BROWN, M. R. C. S., L. S. A., etc.—Aids to Obstetrics. By SAMUEL NALL, B. A., M. B., Cantab., etc. New York and London: G. P. Putnam's Sons, 1855. Pp. viii-112; iv—76; iv—72; viii—142. [Prices, 25 and 50c.]

The Diseases of Sedentary and Advanced Life. A Work for Medical and Lay Readers. By J. MILNER FOTHERGILL, M. D., Physician to the City of London Hospital for Disease of the Chest, etc. New York: D, Appleton & Co., 1885. Pp. viii-296. [Price, $2.]

Rationalism in Medical Treatment; or the Restoration of Chemism, the System of the Future. By WILLIAM THORNTON. Published by the Author, 1885. Pp. 46. [Interleaved—Price, $1.]

Transactions of the Medical Society of the State of New York, for the Year 1885. Published by the Society, 1885. Pp. iv-400-16.

Moisture and Dryness: on the Analysis of Atmospheric Humidities in the United States. By CHARLES DENISON, A. M., M. D. Professor of Diseases of the Chest and of Climatology, University of Denver, etc. Chicago: Rand, McNally & Co. 1885. Pp. 30. Price $1.00.

Transactions of the Texas State Medical Association. Seventeenth Annual Session, held at Houston, Texas, April 21, 22, 23, 1885. Printed for the Association.

The Havre Town Council has voted a sum of £1,000 to M. Pasteur, as a mark of gratitude for his services, and as a contribution towards the expenses of his philanthropic investigation.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, DECEMBER 19, 1885.

Editorial.

THE INTERNATIONAL MEDICAL CONGRESS AGAIN.—The medical profession has recently been assured by the present Executive Committee of the Congress that arrangements have been made for this meeting which anticipate the hearty co-operation of the profession everywhere in developing this great scientific and humanitarian assembly. The "special announcement" which conveys this information has been issued in advance of a statement of facts which is able to confirm so cheering an assurance. We are not desirous of throwing cold water upon the happy anticipations of the present Executive Committee. We earnestly hope the result of their labors will prove as satisfactory to the entire profession, both in America and in Europe, as it appears in the eyes of the Committee. In the absence of definite information we are unable to state upon what grounds so amicable an adjustment of the past differences which divided the profession on the Congress controversy has been reached. We observe that the present Executive Committee has invited the former Committee to unite with it in its work of organization, but this invitation was declined by the Original Committee, except upon the condition that the present Executive Committee unite with them the Original Enlarged General Committee, and recommence the organization *de novo*. We are not informed whether the present Committee, which professes to have such a deep interest in the success of the Congress, has assented to this proposition. It seems to us that the plan proposed is the only harmonious solution of the differences which has been presented. This proposition gives a definite shape to the present muddle and enables all of the discordant elements to meet upon a common platform. A new Committe, consisting of the Original Committee of eight, of the Original Enlarged Committee, and of the present Executive Committee, unrestricted by former appointments, would be able to organize the Congress on an entirely new basis. The appointments of this Committee would be made from the entire profession, and would, no doubt, be given to men who best represent the American profession. The question of the "Code," the aspirations of ambitious office seekers, the claims of Colleges and sections, and the demigogues in the profession would, no doubt, be relegated to the back ground. If it is upon the basis of this plan of organization that the present Executive Committee is warranted in announcing the success of the Congress, we believe its assurances will be verified. Upon any other basis we do not think the Congress will prove a success, and we shall believe that the assurances of the Executive Committee are but empty and hollow promises. We trust a solution of the present differences may be reached after the plan proposed, and that the profession will then join hands over the chasm and work for the success of the Congress of 1887.

A PILGRIMAGE TO PASTEUR.—One of the most notable events which has taken place recently is witnessed in the fact that four little children, who were some two weeks ago bitten by a mad dog in Newark, New Jersey, have been started on a voyage across the Atlantic to visit M. Pasteur with a view of testing the value of his inoculations for the prevention of hydrophobia. As soon as it was ascertained beyond a question of doubt

that the dog was really suffering with rabies, a few generous citizens raised a fund for the purpose of defraying all expenses attendant upon this pilgrimage to Pasteur, and the children, accompanied by Dr. Billings, the well-known veterinarian, and Dr. Biggs, the representative of the Carnegie Laboratory, set out on a voyage which will be watched with the greatest interest by the entire scientific world. The result of this experiment is one which is calculated to arouse the greatest enthusiasm or a corresponding amount of disappointment. We may well watch the result with feelings of anxious interest for we shall witness a test of the eminent scientist's experiments which may prove a turning point in the management of similar cases for all time to come. It so happened that of the six children bitten by this rabid dog two have been left behind, their parents having refused to allow them to make the journey. This circumstance may, after all, have a scientific value in determining the success of M. Pasteur's inoculations, which can not be foreseen at this time, for should the two children left behind develop hydrophobia and the four which are inoculated by M. Pasteur escape, the result will be of the most confirmatory character. Whatever be the result to the scientific world the facts as now presented are unique, and are worthy of the highest commendation. We have every assurance that these American adventurers will receive whatever measure of protection these inoculations of M. Pasteur are capable of affording, and should their death be averted by this eminent and earnest humanitarian and scientist, it is probable that their names will go down in history side by side with their benefactor. Another fact worthy of mention is this. It is stated that Dr. Biggs, the representative of the Carnegie Laboratory, goes to France to study M. Pasteur's methods of preparing his virus and conducting his inoculation experiments with the object in view of introducing these methods into our Country. Should the present treatment stand the test the way will be opened for the introduction of a similar method of treatment in the Carnegie Laboratory, and thus offer an asylum to which unfortunate victims may be sent without the delay necessitated by a trip across the Atlantic. It is one of the distinguishing features of our times that scientific workers are liberally aided by eminent humanitarians whose open purses and generous hearts provide the means for the conduct of their beneficent labors.

Cocaine Intoxication.—The subject of cocaine intoxication has recently attracted some attention in various medical circles, and a few cases have been reported in which these manifestations of this drug were noted. The *London Medical Times* has called attention to a case recorded by Dr. P. Heymann in the *Deutsche Medicinische Wochenschrift*, No. 46, which possesses some points of interest.

The patient, a boy, was suffering only from a small papillomatous growth in the larynx, which had recurred again and again after its removal, once under cocaine, in many sittings. The boy required the use of a very liberal application of the solution to the pharynx and larynx before anæsthesia could be produced. The tumor was quickly removed, but not before the boy began to show signs of intoxication. On being placed on a sofa, he lay for five hours in an apathetic half-sleepy condition with eyes open. "He had no hallucinations, or could recollect none, and when able to speak did so in a hesitating, but nevertheless intelligent, manner. There was considerable difficulty in walking, the gait being very uncertain. He did not complain of hunger or of any special pain, only of general feelings of discomfort. The pupils were not dilated, but reacted normally to light. Pulse, temperature, and respiration appear to have been all slightly increased, but both the heart and lung movements were otherwise normal and regular. At a rather later stage the difficulty of walking was increased, owing to an apparent inability to control the movements of the legs. The symptoms did not pass off until ten hours after their onset, the patient then for the first time obtaining

sleep, from which he awoke but little worse, apparently, for his experiences of the previous day."

M. Pasteur and His Inoculation Experiments.—The attention of the scientific world is now earnestly concentrated upon the experiments of M. Pasteur with the virus of rabies, and greater interest is manifested in the results of his investigations than has ever been shown in any line of scientific enquiry. This learned savant is passing through a most trying ordeal, yet with undaunted courage and firm faith in the ultimate triumph of his method, he is meeting every emergency to which his investigations can be subjected. Up to the time of writing over seventy persons bitten by rabid dogs have been inoculated at his laboratory. Patients are arriving from all parts of France, and recently children bitten by mad dogs have been forwarded to him from Newark, in New Jersey, and from Canada. Notwithstanding the length of time which may have intervened between the bite of the dog and the beginning of the inoculation experiments, M. Pasteur undertakes the cases, though he has stated after hydrophobic symptoms break out the inoculation experiments are hopeless. A child was recently brought to him thirty-six days after the bite. She was bitten in the head, the dog's teeth getting in close proximity to the brain. When the girl was first brought to his laboratory, M. Pasteur refused to treat the case as he considered it a hopeless one. Acting under the advice of the highest medical authorities he concluded to make the attempt. The result, however, was of no value to the girl, since the virus had already developed to such a degree that inoculation failed. The death of the child soon followed from hydrophobia. This result, M. Pasteur very properly claims, is no disparagement of his treatment. He insists that it is urgent that cases should reach him as soon as possible after the bite, although there is always a chance of successful inoculation so long as hydrophobia has not set in.

One cannot but admire the modesty and scientific spirit which pervade M. Pasteur's work. He asks that time be given him to form a final judgment upon the value of his inoculation experiments.

Medical Politicians in England.—Our contemporary, the *London Medical Times* (November 28th, 1885), devotes the following remarks to the medical aspirants for political honors in England. The statement goes to show to what extent our English medical brethren are willing to be spent in patriotic service as law-makers. It is quite evident that the talent of our profession in the Mother country is not content with purely medical honors, but seeks a wider field of usefulness and of intellectual exercise than is afforded by the routine of medical or surgical practice.

"As far as the elections have yet gone, only two members of the new Parliament can be claimed by the medical profession, viz., Sir Guyer Hunter, whose election for Central Hackney will cause wide satisfaction, and Mr. Vanderbyl, the new Liberal member for Portsmouth. Sir Guyer Hunter brings to the House of Commons a special knowledge, and an administrative ability, and an energy which will be extremely valuable. Men with experience of India always hold a peculiar position of authority in the House, but when to that experience is added, as in Sir Guyer Hunter's case, a sound knowledge of medical and sanitary science, the collocation becomes unique. Sir Guyer Hunter, who is a K. C. M. G., received his medical education at Charing Cross Hospital. He entered the Indian Medical Service, Bombay Presidency, in 1850, and served throughout the Burmese War and the Indian Mutiny. In 1876 Sir Guyer Hunter was appointed Principal of the Grant Medical College, and in 1879 Vice-Chancellor of the University of Bombay. He retired in 1880, and on the outbreak of cholera in Egypt was dispatched by the Government on a special mission to that country, the incidents of which will still be in the memory of our readers. Mr. Philip Vanderbyl, the member for Portsmouth, was born at the Cape in 1827. He was educated at the Edinburgh Uni-

versity, where he graduated with honors in medicine and obtained a gold medal. He subsequently became a member of both the Royal College of Physicians and the Royal College of Surgeons. He has been President of the Royal Medical Society of Edinburgh, and was subsequently a lecturer on anatomy and histology at the Middlesex Hospital. He retired from practice in 1858, and is now an Australian merchant and banker, and a director of the East and West India Dock Company. We hope that by next week this list will be considerably increased. Besides the well-known candidatures of Mr. Erichsen, Mr. Earnest Hart, Dr. Alfred Carpenter, and Dr. Herbert Watney, the medical candidates include Dr. Balthazar Foster (Cheshire), Dr. Danford Thomas (West Islington), Dr. P. Royle (South Manchester), and Dr. Macdonald (Ross and Cromarty), and Dr. Finlay, Q. C. (Inverness Burghs); though the last two have forsaken medicine for the law. If a fair proportion of these candidate are returned, and the old medical M. P.'s re-elected, we ought to have a compact little phalanx in the Lower House which will have much weight in medical and sanitary affairs."

Miscellany.

Habitual Abortion and Kidney Disease.—At the recent meeting of German scientists and medical men at Strasburg, Dr. Fehling, of Stuttgart, read a memoir on habitual death of the embryo in kidney disease. In the first case under his observation, premature expulsion of a dead fœtus occurred six times, and there was no evidence of syphilis. At every pregnancy, anasarca, albuminuria, and death of the fœtus, with severe cramp of the abdominal muscles, occurred, between the fifth and sixth month; the dead fœtus was expelled from three to ten weeks later. In the second case, similar symptoms appeared in a young unipara; the fœtus died, and thereupon the albuminuria abated. In the third case, the patient had borne two healthy children. During her third pregnancy, albuminuria and characteristic changes in the retina occured; and, during the fourth, she was seized with hemiplegia; in both, a decomposed fœtus was expelled at the fifth month, with subsequent decrease of the albuminuria. In the fourth case, the patient, in her first pregnancy, aborted at the fifth month; then she gave birth at term to a recently dead child. In the third pregnancy, great œdema and albuminuria supervened, the child was stillborn, and the mother died of uræmia. Dr. Fehling believed that, in all these cases, kidney disease existed before pregnancy, which aggravated the renal symptoms. Winter had described two cases of premature detachment of the placenta, normally situated, where albuminuria existed. Dr. Fehling found atrophy of the villi of the chorion, with wedge-shaped or spherical infarcts in the placenta, in his cases, similar to renal infarcts. The infiltration of the chorionic villi and vessels of the umbilical cord with small cells, as seen in syphilis, was absent, nor did any of the embryo exhibit a trace of congenital syphilis.—*British Medical Journal*, November 21. 1885,

Tootache.—The writer of the following, which appeared in the editorial columns of the *New York Herald*, (December 10th, 1885,) has evidently had an experience. As a clinical observer he will rank with the best.

"The man who never had the tootache has failed to touch bottom in the sea of useful and awful experiences. George Washington was a good man and a thoroughly moral man, but the tootache never failed to bring expressions from his patriotic lips which no honorable journalist ever presents in type. The rest of us, who are inferior to the Father of his Country, have what Sam Weller called "a gift o' gab werry gallopin'" under such circumstances.

It is said by those who konw that every man is accompanied by two angels. The one over his right shoulder writes down every good thing he says, while the one over his left shoulder makes a note of everything evil. Now, whenever a man has the tootache these two angels take a vacation and go fishing. Nothing good can be said, which dispenses

with the services of the angel over the right shoulder. The angel over the left shoulder knows full well that the tooth-ache renders a man irresponsible and that it wouldn't be quite fair to repeat his remarks, so his services also are dispensed with. Then, when a poor wretch is all alone, with no one to hear what he says, he just unchains his tongue and talks with an astonishing degree of license.

Teeth have their uses, but they ought to behave themselves."

Treatment of Fracture of the Thigh in Children by Means of the "Steadle-Splint."—S. Wilson Hope, Petworth, Sussex, says in the *British Medical Journal:* By the steadle-splint, or crib-splint, is meant the using a steadle, bedstead, or crib, for the purposes of a splint, namely the extention and counter-extension; and any futher appliance for setting, or coaptation, may be omitted, with good results. One method of using it which answers very well, is this. From an ordinary bandage cut such a length as, when folded in the middle, will reach from the lower ribs of the child beyond the top cross-piece, forming part of the framework upon which the mattress rests; whether it be the framswork of an iron bedstead, of a crib, or of an old wooden steadle. Take two such lengths, and lay them singly, not doubled, along the sides of the child's chest; and pass round the chest, under the arm-pits, and over the bandage-lengths, an ordinary rib-roller. On bringing up on the outside of the roller the other ends of the bandage-lengths, there is on each side of the chest a loop of bandage, with the rib-roller lying in the loop. Let the upper and the under portion of the bandage be secured separately by thread or safety-pins to the upper edge of the rib-roller, and at such points that the under part goes under the shoulder, and the outer part over the shoulder, without dragging. Adjust the child's head and pillow, and fasten the bandage-length to the top cross-piece, which forms part of the framework upon which the mattress rests. And one has only to raise the feet of the bedstead upon bricks, when the arrangements for counter-extension are complete. Cover the ankle thickly with wadding, and, having taking a loop-length of bandage, long enough to reach from the angle, beyond the bottom cross-piece, forming part of framework which supports the mattress, tie the bandage round the ankle, with the knot at the back, above the heel; make extension, and secure to the bottom cross-piece. All that remains is to keep the foot in position by means of bandage-lengths passing round the foot, and fastened to the side-pieces of the framework; and the thigh is set. The main use of such a plan as this is that, in whatever out-of-the-way house one finds a child with a broken thigh, there, also, is the steadle-splint.

But, besides, the following points might be mentioned in its favor. 1. It avoids all trouble consequent upon perineal bands in children. 2. The counter-extending bands over the shoulder check both forward and turning over movements during sleep, as well as when awake. 3. In permitting the omission of special setting splints and all bandaging, it adds to the comfort at the time and throughout the treatment.

The International Medical Congress of 1887.—A meeting of members of the medical profession interested in the International Medical Congress in 1887, to which prominent medical men from a number of cities were invited, was held at the Hall of the College of Physicians, Philadelphia, December 4, 1885, Dr. D. Hayes Agnew in the chair.

It was stated that official notice had been given of the election, as members of the present Executive Committee of the Congress, of Dr. J. S. Billings and Dr. J. M Browne, of Washington, D. C.; Dr. Christopher Johnston, of Baltimore; Dr. George J. Engelmann, of St. Louis; and Dr. J. M. Da Costa and Dr. William Pepper, of Philadelphia.

A general and strong expression of opinion was made in support of the American Medical Association and its Code of Medical Ethics, and sincere regret was expressed that hasty action on

the part of the association, and the introduction of false issues, had imperiled the succecs of the Congress. It was made entirely evident, however, that the acceptances of the above elections would not be regarded as affording any adequate guarantee for the future scientific conduct of the Congress, and, consequently, would not be followed by any co-operation on the part of the leading members of the profession now unwilling to join in that work. As an evidence of the earnest desire which is felt for the restoration of harmony upon this subject, and for the reorganization of the Congress on a basis which would command general support, and thus insure success, the view was unanimously expressed that if the present Executive Committee, should unite with them the Original Enlarged General Committee, and recommence the organization *de novo*, this course would insure the desired result.—*N. Y. Med. Jl.*

The Prevention of Mammary Abscess.—Philip Miall, Consulting Surgeon to the Bradford Infirmary, says in the *British Medical Journal:* A method of treating inflamed breast after delivery may be worth notice in connection with Dr. Edis's paper on the use of support by a bandage or towel. Dr. Edis appears to use his method after every deliverv, and, by beginning it before lactation is established, assures success; but one occasionally sees cases where abscess is on the point of forming, either from neglect or injudicious treatment, and where, consequently, something more is required.

I have repeatedly seen a hot, heavy inflamed breast, with redness of skin, throbbing, and deep seated pain, the pulse being 120 in the minute, yet these symptoms have disappeared in the course of a few hours under fomentation with hot water and ammonia. An ounce of carbonate of ammonia is dissolved in a pint of boiling water, and, when solution is affected, the temperature will scarcely be too high for fomentation with cloths dipped in the liquid. These must be assiduously applied for half an hour at least, and repeated two or three hours later if necessary. It is well to protect the nipples, though I have never known them to be injured. Relief is immediate, and more than three applications are seldom required.

Unless applied too late, or improperly, or some foolish rubbing or drawing with the breast-pump be used, contrary to orders, this remedy may be thoroughly relied on. I am indebted for it to Mr. Douglas, of Banbury; and as it has had a trial of thirty years in my hands, I can speak of it with some confidence.

Wishing to be Let Alone.—By an extraordinary process of reasoning, the *Journal of the American Medical Association* attempts to show that there is now no longer any reason for criticism, protest, or discussion regarding the management of the International Medical Congress. Having turned a masterly somersault in defending as parliamentary a procedure that it at one time was at extraordinary pains to condemn, it now believes that every one should cease complaining, and let its affronts and inconsistencies alone. We are strikingly reminded of a once popular poem concerning an "old cove" who sat in an advantageous spot and shied stones at the passers-by. He, too, only wished "to be let alone."

It is, however, not reasonable to expect that a policy which excludes so many leading men from all honorable connection with the Congress, shall not continue to be criticised. —*Medical Record.*

Ruptured Perineum.—In bringing before the class a case that he had recently operated upon, Dr. Goodell took occasion to urge upon the class not to make *skin* perinei; they should be thick. A skin perineum will look well enough, but it will not afford support. To perform the operation properly, you must denude boldly, and dissecting a flap from the posterior wall of the vagina, unite it with the other tissue; this will give a perineum with the natural slope. When operating immediately after the labor at which the rupture has occurred, this, of course, will not be necessary, but we must then

be careful to plunge the needles deeply, to do which we must have a good light; candle-light will hardly answer. This woman was operated upon one week ago. He amputated the cervix and sewed up the perineum; he now takes out the stitches and finds good union. When the sphincter is not torn, there is no necesity to draw the water—the urine is usually bland, and will do no harm; though, when convenient he prefers to draw it. To remove the stitches, he places the woman on her back, while an assistant holds aloft her legs, that are tied together. It is always well to remove the bowels before removing the sutures. In a couple of days he will loosen the legs, that have been tied together since the operation.—*Med. and Surg. Reporter.*

Cocaine in Whooping-cough.—Dr. Prior, of Bonn (*Berliner Klinische Wochenschrift*), has treated several cases of whooping-cough with cocaine, with good results. As is evident on *a priori* grounds, he does not consider the drug a specific, but simply a means of relieving and reducing the number of the paroxysms. He used fifteen and twenty per cent. solutions to paint the fauces, the interarytenoid fossa, and the vocal cords, with the result of prolonging the interval between the attacks, and lessening the severity of these. The treatment was resorted to twice daily, great stress being laid on the necessity of producing at the time complete anæsthesia of the fauces and upper part of the larynx. Inhalation of a twenty per cent. solution four times a day was not so successful as painting.—*British Medical Journal*, November 21, 1885.

Conception While the Uterus Contained a Placenta.—Dr. W. M. Trow, of Northampton, Mass., gives an account in the *Medical Record* of the following case: "Mrs. ——, a fleshy woman, and the mother of three children, regular in her periodicals except during pregnancy, passed her period in February, 1885. In March she was normally unwell, and was regular till August, which she passed. In September she again menstruated. In October she was taken with considerable flow and severe pain, which continued for twenty-four hours when I called to see her. On my arrival I found a three months' fœtus, which she expelled just before my entering the house. The placenta was partially detached, and occupied the mouth of the uterus. Under the influence of ergot it came away in a short time in a normal condition. The following day she was feeling well; the flow as usual in such cases. Four days after I was again called, and found that she had been flowing for twenty-four hours, and suffering severe pain most of that time. An examination revealed the mouth of the uterus open enough to admit two fingers, and occupied by a fleshy mass which was firmly attached to its fundus. I gave chloroform and introduced my hand into the vagina, when I was able to detach the mass, which was at once expelled. It proved to be a placenta as large as is usually found in a conception of four or five months. Pain and flowing at once ceased, and she made a fair recovery. This was a unique case with me in an experience of some thirty years."

Carbolic Acid in Indigestion.—Berdoe has frequently treated acid dyspepsia with small doses of carbolic acid. He uses a solution suggested by Dr. Fenwick, containing one part of the crystalized acid in four parts of glycerin, and gives from five to ten minims as a dose either merely diluted or mixed with nux vomica or liquor opii sedativus, the latter being added in case of pain. He does not attempt to explain the action of the drug, but suggests that its efficacy may be due either to its anti-fermentative power or to the anæsthesia which it induces in the gastric mucous membrane. —*New Medical Journal.*

Medical and Surgical History of the War.—The manuscript of the third medical volume of the "Medical and Surgical History of the War," and the last of the series, is now well advanced toward completion; its earlier chapters are in the hands of the printer. They will probably be ready for issue during the coming winter.—*Med. Record.*

The Carnegie Laboratory.—Dr. Herman M. Biggs, instructor in the Carnegie Laboratory, sailed for Europe in the Ems last Wednesday. The object of his mission is to visit the laboratory of Pasteur and learn all he can from him in reference to the preparation of the virus for the inoculation against hydrophobia. He will then visit Koch's laboratory in Berlin, and obtain from him his views upon this subject of inoculation. He will then go to Cambridge, and pay his respects to John Burdon Sanderson, whose work in this department has a world-wide reputation. After a visit to Edinburgh, Glasgow, and London, he will return in two months to institute some elaborate experiments on a large scale. A small farm will be provided in connection with the Carnegie Laboratory where a system of inoculations can be perfected and some observations made in reference to diseases due to a special microbe.

Mr. Carnegie has just presented the Bellevue Hospital Medical College with six thousand dollars for the purchase of more scientific apparatus in addition to the five thousand dollars for this purpose which he gave last year. He has further signified his willingness to contribute annually for the support of this institution and for the purpose of encouraging scientific work. Dr. Biggs has gone to Europe independent of the Newark children, and his entire expenses have been defrayed by Mr. Carnegie. It is a matter of no small importance that an institution can send to Europe a scientific man for any special observation, and this fact with many others betokens a great future for American medicine and surgery. There are now three paid assistants in the Carnegie Laboratory, and one hundred and forty students and practitioners daily at work in the building, and great results are to be expected from an institution which is carried on upon such a liberal basis

Within the next six months four original papers will appear which will represent original work done in the Carnegie Laboratory.—*N. Y. Med. Jour.*

Cocaine in Hydrocele.—Dr. G. A. Atkinson says in the *Lancet*, October 31: "After the withdrawal of the fluid from the hydrocele sac, it is easy to inject thereinto a drachm, more or less, of a five per cent. solution of the salt named, allow it to flow over the interior, and after five to ten minutes inject the selected iodine preparation, which will not give rise to any pain until an hour or more has elapsed, which pain, usually not severe, if necessary can be controlled by the exhibition of a morphia suppository, or by some similar means. The use of the cocaine salt in this manner further allows kneading of the sac after the iodine injection, which kneading Davy and others have strongly insisted on; and while, on the one hand, paralysis of the sensory nerves ot the serous membrane can, as Cohnheim showed, have practically no retarding influence on the development of the inflammation, on the other, no evil effects can follow the absorption of a quantity of cocaine so far below a toxic dose. To the extent of my limited experience, cases thus treated progress, with the exception of the pain, precisely as those in which no cocaine is employed."

Gonorrhœal Rheumatism. — At a stated meeting of the Cincinnati Academy of Medicine, held October 19, 1885. Dr. Robert W. Stewart reported a case of Gonorrhœal Rheumatism, and gave the following as its characteristic symptoms.

1. It is usually antipyretic or of low degree.
2. Generally confined to one joint, most often the knee.
3. The pain is also less severe than in acute articular rheumatism.
4. There is a marked tendency to hydrarthrosis.
5. There is not the profuse sweating of acute articular rheumatism.
6. The inflammatory buffy coat is not present.
7. An ophthalmia is a common concomitant of the rheumatism.

Vomiting of Pregnancy Treated by Artificial Feeding.—Dr. Brünniche re-

ports in the *Hospitals-Tidende*, No. 29, 1885, the case of a pregnant woman who suffered from uncontrollable vomiting. After trying a great many things without success, the author obtained a cure by feeding his patient through a tube introduced into the œsophagus, but not into the stomach. Milk, broth, powdered beef, and other materials were introduced in this way and retained on the stomach, but as soon as the patient attempted to swallow the vomiting began again. At the end of three weeks, however, the vomiting was permanently controlled and the patient was able to take food in the ordinary way.—*Medical Record.*

A New Remedy for Sea-Sickness.—Dr. G. W. Noad writes the *British Medical Journal:* Having noticed in the *Journal*, of September 26th, some remarks on the use of cucaine in sea-sickness, by Professor Manassein, I thought I would follow his directions in the case of my son, aged 24, who was about to sail for Calcutta, and who, on former voyages, had suffered excessively from sea-sickness. I gave him a solution of hydrochlorate of cucaine (1 in 1,000). He started on October 5th, and writing from Port Said reports as follows: "Sailing on Monday, I was ill on Tuesday night and Wednesday morning but quite well between the attacks. Once more, when the weather was very rough, and the ship rolling terribly, I felt squeamish, but two teaspoonsful of the cucaine put me all right." He adds: "I have missed only three regular meals but had mine at these times on deck. Only one other passenger has suffered less than I have; all the others have been very ill. Other voyages, I have always been the worst on board; and I think the cucaine must have the credit of the improvement." Other letters have been received, but, as no mention has been made of any return of the malady, we conclude he has remained well.

Intestinal Obstruction. — There seems to be great diversity of opinion in regard to the question of the treatment of intestinal obstruction. Some men advocate immediate operation, while others would resort to every other measure first. That we may have some distinguished authority to guide us in this grave situation, we note Mr. Jonathan Hutchison's closing remarks in the *Medical Press*, October 7. He says:

"I advise that very early in all cases of obstruction the attempt at what I have called the abdominal taxis should be done patiently and thoroughly, and then I would wait a long time. I would use belladonna, laxatives, repeated abdominal taxis. I would avoid injury. I would do a lateral operation, and as a last resort I may be driven to open the abdomen in the middle line, and do the best I can. If it be possible to cut into the bowels, and so empty them, then I think laparotomy has been very much simplified."

It seems to us, after reviewing the subject, that if we can make any kind of an accurate diagnosis as to the locality of the obstruction, early operative interference is called for, before the possibly incarcerated gut has had time to become gangrenous.—*Med. and Surg. Reporter.*

How to Blister Quickly.—Put a few drops of the concentrated water of ammonia (aqua ammoniæ fort.) in a watch-glass, butter-dish, shallow cup, or other article of like nature, and cover with a pledget of cotton. This inverted and pressed closely to the spot to be blistered, will accomplish this object in from 30 to 60 seconds. It should afterwards be treated as if produced by cantharides.—*Southern Clinic.*

Ephemeris Discontinued.—Dr. E. R. Squibb announces the discontinuance of the interesting little series of pamphlets which, for the past few years he has issued under the name of "An Ephemeris of Materia Medica, Pharmacy, Therapeutics, and Collateral Information."

The Physicians of Philadelphia number 2,500. New York has about 2,900. In Baltimore there are about 700, while Washington, D. C. has over 200.

Medical Items.

Virchow's Archives has commenced its one hundredth volume.

Among other charitable bequests the late Wm. H. Vanderbilt left $100,000 to St. Luke's Hospital, New York.

Dr. H. F. Formad, of Philadelphia, will deliver the Mütter Lectures before the Philadelphia College of Physicians, on Tuesday and Friday evenings in December and January.

Dr. Van S. Lindsley, Professor of Diseases of the Eye and Ear in the Medical Department Vanderbilt University, at Nashville, died after a painful illness, November 15th ult.

Mr. East, in the *British Medical Journal* gives a practical hint with regard to the treatment of phimosis. It is to use thin strips of gentian-root as wedges, inserting six or eight between the glans and prepuce.

A young woman who lately took a medical degree in Paris has been appointed medical examiner of girls in the municipal schools of Paris, her duties being to see that the girls are not overworked and that they accomplish their tasks under good sanitary conditions.—*Boston Med. and Surg. Jl.*

The secretion of urea is increased by salicylate of soda, benzoate of soda, euonymin, iridin, colchicum and corrosive sublimate. These substances also increase the elimination of water (excepting colchicum and salicylate of soda). When large or purgative doses are used, the increased elimination of urea is less marked.—*Med. World.*

Dr. James Sawyer, of Bermingham, England, has been recently elevated to a knighthood in recognition of his eminent professional services. It is stated by the *London Medical Times* that the bestowal of this honor upon him is a happy recognition of the claims of the medical profession in the growing provincial towns to a share of the honors hitherto mainly confined to practitioners in London, Edinburgh, and Dublin.

Carbolic acid in a ten per cent. solution applied with general friction over the whole surface was successful in the cure of a horse with tetanus after complete failure of chloral. In another case similar friction with a five per cent. solution was equally successful. Absorption of carbolic acid takes place quite rapidly through the skin of animals when applied with friction.—*Courier of Medicine.*

A little girl in Watertown, N. Y., who was dying of scarlet fever, desired to send a kiss to a little playmate in another town. She kissed the letter, which was sent by mail to the little friend, who, wholly unaware of the danger incurred, kissed the letter as a message from her dead friend. In a few days she herself died from scarlet fever contracted by means of this kiss.—*Courier of Medicine.*

A bill is being prepared by the New York Medical Society asking the State Legislature to include cocaine in the list of drugs forbidden to be sold excepting on physician's prescriptions. It is said that in New York many drug stores sell a paste made up of coca leaves and lime forming a cud similar to that used by the Peruvians as a stimulant. These preparations are in great demand.—*Med. Review.*

M. Pierre Vigier (*Gazette Hebdomadaire*, February 6,) states that for injection in gonorrhœa the lactate of quinine is the best preparation of quinine, owing to its greater solubility. His formula is lactate of quinine 1 gramme, distilled water 75, and glycerine 25 grammes. About five grammes should be injected three or four times a day. M. Vigier takes the opportunity of recommending practitioners to more and more employ the lactate in preference to any other preparation, whether for internal, or hypodermic use. It is the salt which is best adapted for every therapeutical application.—*Med. and Surg. Rep.*

Original Articles.

SOME CASES OF TARDY FIRST STAGE OF LABOR, AND THEIR TREATMENT.*

BY ELLIOTT RICHARDSON, M.D., OF PHILA.

The following cases have been of interest to me and I trust will be so to others. Most of them represent intances of certain forms of dystocia which are neither new nor very rare, and the treatment of which is often a matter of censure to the accoucheur.

Mrs. M., æt. 28 years, born in England, a very light blond of more than medium height and apparently well formed, was taken in labor with her first child early in the morning of February 18th, 1883. Her previous history was uneventful in a clinical point of view, no evidence having been elicited of any protracted or violent illness or of any hereditary taint of any kind. The pains were not at first severe, but became more so as the labor advanced. I saw her in the evening of the 18th, when I found the os dilated to about the size of a quarter of a dollar, thin but soft and not sensitive to the touch. During the pains, the bag of water, which was very small, seemed to press but lightly through the os. Through the membranes the presenting head was felt in an attitude of semi-extension with the anterior fontanelle occupying nearly the centre of the field. The occiput was directed toward the left acetabulum. The presenting head was held at the superior strait and did not advance during a pain, but it so closely fitted the lower segment of the uterus as to completely separate the amniotic cavity above from that below and to prevent any addition being made to the small amount of liquor amnü contained in the bag of waters. Nor did the head show any disposition to become flexed either during a pain or its absence. Labor continued with moderate pains, during 19th and 20th, with but little effect upon the os, so far as could be perceived by the touch, although it was evident that a very slow dilatation was being effected. The condition of the patient during this time remained good and gave no occasion for anxiety or alarm. On the morning of the 21st, the fourth day of labor, however, symptoms of exhaustion became apparent. The pulse ran up to over 100 per minute and increased bodily heat was associated with a tendency to dryness of the mucous surfaces. Still but little progress had been made in accomplishing the dilatation of the os which was at this time opened to about the size of a half-dollar. It was still impossible, without artificial dilatation, to attempt either version or forceps delivery. The head had not advanced and still plugged up the lower segment of the uterus as effectually as ever.

Two courses were open to me. One was to dilate the os artificially and apply forceps or turn; the other was to support the patient's strength by securing to her needed rest, while at the same time promoting perfect relaxation of the soft parts, hoping that sufficient dilatation would under this treatment soon enable me to rupture the membranes, when the head being exposed to pressure from the uterine contractions above it would fairly engage, and, it was hoped, descend through the os uteri and the superior strait. The latter course was chosen, and in order to carry out the treatment a sixth of a grain of sulphate of morphine was given every four hours, while the severity of the pains was still further mitigated by inhalations of chloroform at the beginning of each pain. Under this treatment the general condition of the patient improved; she slept regularly between the pains and in that way got much rest. By 10 o'clock in the evening sufficient dilatation had been secured to justify me in rupturing the membranes when the head descended and soon the second stage of labor was established. This terminated successfully for both mother and child at about 11 o'clock that evening. Thus was the labor happily and safely concluded after a duration of about ninety hours, by the use of constitutional means alone. The external measurement of the pelvis subse-

*Read before the Obstetrical Society of Philadelphia, December 3rd, 1885

quently taken with care showed the following dimensions:

Between ant.-sup. sp. process,	$8\frac{5}{8}$	inches,
" crests,	$10\frac{7}{8}$	"
External conjugate,	$6\frac{1}{3}$	"
Real conjugate by inference.	$3\frac{1}{3}$	"

The relations of the measurements of the distances between crests and anterior spinous processes precludes, almost to a certainty, the existence of a rachitic pelvis and as all the measurements were somewhat below the normal the small pelvis was probably one of those in which the sexual development of the pelvis was imperfect, that is, arrested in its progress. The attitude of partial extension observed in the fœtal head in the case just given is explained by the fact that the extremities of the narrowed conjugate diameter formed the points of resistance to the descent of the head, and as there would naturally offer much more obstruction to the descent of the greater diameters near the occipital extremety than to the narrower ones near the face, the latter extremity would of necessity descend first. In the last day of the labor I had the benefit of the advice of Dr. Albert H. Smith, who then for the first time saw the case with me.

On March 25th, 1885, I saw in consultation with Dr. Hampton, Mrs. M., in labor with her first child. She had been in labor for nearly twenty-four hours without making any great apparent progress, On examination I found the os dilated to about the size of a half-dollar and presenting no abnormal conditions. The bag of waters was small and did not seem to press with any force through the os during the pains. The head presented in the second position and was held in a partially flexed attitude at the superior strait. The patient was much alarmed by the slow progress she was making so that the pains were becoming very rapid without materially aiding in the advancement of the labor. The treatment adopted in this case was rest in bed, one sixth grain of morphia every four hours and inhalations of ether at the beginning of each pain. The membranes were ruptured as soon as a greater amount of dilatation had been secured and twelve hours after I saw the case, she was safely delivered of a living child. No opportunity was afforded me to measure the pelvis after the termination of the labor. This case differs from the first in degree only, the nature of the impediments to the progress of the labor being the same. In both the dilating wedge usually afforded by the bag of waters was wanting because the closely fitting head prevented access of any considerable amount of liquor amnii to that part of the amniotic cavity which was in advance of it, and the head itself did not advance because it was held at the brim of the pelvis by the narrow conjugate. While in normal labor, before the membranes are ruptured all parts of the fœtus are exposed to a like pressure because that pressure is communicated to it by the liquor amnii; when the head cannot advance, and at the same time prevents any part of the liquor amnii descending past it into the bag of waters, this equilibrium of pressure becomes destroyed, that part of the fœtus which lies above the line of contact of the head with the uterine walls receiving the full force of the contractions of the uterine muscle while that part which is below only receives the force of resistance offered by the cervix. Hence when the latter is soft and dilatable a process of moulding or adaptation of the presenting part gradually approaches the os and tends to dilate it by affording that dilating wedge which is absent at an earlier period of the labor. When the head by this process approaches so close to the membrane closing the os as to exert considerable pressure upon the latter, all further moulding ceases, but, at the same time, dilatation of the os becomes more rapid so that soon it will have progressed to a sufficient degree to justify rupture of the membranes. The effect of such rupture is to relieve the head of all impediment to the further progress of moulding and elongation. It is now thrust downward and if the pelvic narrowing is not great will soon pass through the brim and into the os; the latter being exposed for the first time to the whole dilating power of the uterus readily yields. The peculiarity of the first stage of labor

which in all its important bearings upon the welfare of the woman and fœtus widely distinguish it from the second stage, is that so long as the membranes are intact, the relations of the two beings to each other are precisely the same as those existing during the course of gestation so that almost indefinite delay is perfectly consistent with the entire safety to both. Notwithstanding this fact the first stage of labor is often a period of great danger to both. The danger to the mother is from exhaustion and, exceptionally, from rupture of the uterus; that to the fœtus is from asphyxia due to the two frequent or too powerful uterine contractions. The mother will only become exhausted when the pains become so frequent, so violent or so long continued that she is not able to restore her strength from time to time by sleep and perfect rest between the pains. The same condition with regard to the nature of the pains, early rupture of the membranes and, probably, some abnormal state of the tissues of the uterus are essential to the production of rupture of that organ. The risk to the fœtus is due to the same condition of the uterine contractions as those which impair the mother's strength —in which the time intervening between the pains is not sufficient for the removal of the vitiated blood from the maternal part of the placental circulation and the supply of arterial blood in its place. In considering the relations of the woman and fœtus to each other, and the nature of the dangers which threaten each in the first stage of labor, the indications for treatment might seem to be obvious. They are to preserve the proper strength and rythm of the uterine contractions in order to secure needed rest to the mother and sufficient regularity in the placental circulation to supply the fœtus with enough oxygen for its preservation. When therefore it is obvious that from any cause the dilatation of the os uteri must be a prolonged process, we should take care to protect both the woman and the fœtus from danger during its progress. Even weak uterine contractions may, by becoming nearly continuous, produce the dangers already alluded to, and so while endeavoring to strengthen them, care must be used to preserve this rythm. In the cases which I have reported this principle was adopted in treatment. Nothing was done until the pains became abnormal in character when the measures already detailed were instituted. In both cases morphia was used by the mouth; in one case inhalations of chloroform, in the other ether were used in conjunction with the opiate. In view of recent experiments there can be no doubt that ether is the safer remedy of the two, and yet it possesses so many disadvantages when compared with chloroform, and the risk from the latter when carefully used in these cases and in conjunction with the use of opium in some form is so slight that it is a question in my mind whether we are not often justified in using chloroform in preference. During the first stage of labor, if no painful operation is to be performed, it is not necessary nor even desirable to produce complete unconsciousness. The anæsthetic is given to mitigate pain, not to entirely destroy consciousness of it, and at the same time prevent both mental and uterine irritability. Opium and chloroform supplement each other to a great extent, so that when the effects of the two are combined a much smaller dose of each is required to produce a given effect than when ether is used alone. This is not so with opium and ether, or to so slight an extent as to be almost inappreciable. While in a woman in labor who is under the moderate influence of opium, but a small amount of chloroform administered by inhalation is sufficient to give all the relief from pain needed. The quantity of ether to be used to produce the same beneficial effect will not be found to be less than when no opium has been given. The practical result of this relation of the remedies to each other is that in the former case the patient's suffering is relieved at once, while in the latter some time is required before any decided amelioration is experienced. In support of the above assertions I may be permitted to quote somewhat at length from the able paper of J. C. Reeve, M. D., of Dayton, O., which appeared in the *American Journal*

Medical Sciences, for July, 1880. In the course of his review of Dr. Kappeler's book on anesthetics, Dr. Reeve says: "The modification of the ordinary course of anesthesia by the preliminary injection of morphia deserves attention. * * * * It is claimed for this 'mixed narcosis' that it is especially adapted to prolonged operations by rendering a far less quantity of chloroform necessary. The anesthesia being continued with far less frequent repetition of inhalation, that the stage of excitement, both muscular and mental, is lessened and that thereby the dangers of anesthesia are diminished. Mollow, one of its enthusiastic advocates, goes further, and claims that the action of the morphia lessens irritability of the air passages and so restrains reflex action upon the heart, that in this respect its effect is similar to the division of the *par vagum*, also that the morphia in small doses increases the blood pressure by its action on the motor ganglia of the heart and by its contraction of the peripheral vessels thereby opposing the chief deleterious influence of chloroform from the beginning by presenting an opposition which must be overcome before the vascular pressure can sink below the normal." As to the smaller quantity of chloroform necessary for a given length of anesthesia, the less amount of muscular excitement and the modified mental condition, Dr. Kappeler says, the advantages have been on various sides clinically proved, and are only seldom called in question. The advantage claimed by this method have been denied by Demarquay, but confirmed by Heitel, and in part by König. The latter does not, however, believe that the dangers from chloroform are all diminished by the use of morphia. Dr. Reeve further states that "none of the advantages of chloroform-morphia narcosis attach to ether-morphia narcosis," and that Dr. Kappeler's "experience * * * seems to show that in all respects the combination is injurious rather than beneficial." Reference is made in the paragraphs which I have quoted to the use of the agents mentioned in surgery alone. They apply in the main to obstetrics as well, although I do not see any disadvantage in theory, nor have I in practice in the ether-morphia narcosis as compared with ether-narcosis alone. In comparing the effects of chloroform and ether in the first stage of labor, the former has, I believe, a decided advantage in its effects upon the os uteri, in promoting relaxation. All the advantages above attached to it are at the same time coupled with its easy and pleasant administration. Against these, however, must be offset the danger from its use. Exactly how great this danger may be in careful hands cannot be told. In many cases of fatal chloroform poisoning it has been the few drops that killed; in such cases, therefore, the diminished amount rendered necessary by the morphia previously given would be no safeguard. I believe, however, that the danger is so infinitely small when thus given that we are justified in using it in painful cases of labor, especially when the chief difficulty lies in the rigid condition of the cervix or other soft parts of the parturient canal, and that in such cases the use of morphia, either by the mouth or hypodermically in moderate doses, greatly facilitates the accomplishment of the end in view. At the same time I would not be understood as advising the use of chloroform instead of ether in ordinary cases of painful labor. Since in these the only object is to relieve pain, ether answers the purpose and being the safer remedy should be preferred.

Another cause of tardy first stage of labor is *premature rupture of the membranes*. This accident is apt to interfere with the progress of labor in the stage of dilatation by the absence of the dilating cone formed by the membranes in normal cases, and by direct contact of the presenting part of the fœtus with the uterus. Owing to the former the uterine force is exerted at a disadvantage and by the latter the os is apt to become rigid, dry and sensitive, while the mother's suffering is much increased. The fœtus is exposed to exceptional risk when obliged to pass through the entire stage of dilatation of the os without the protection of the liquor amnii, for not only are its parts

subjected to injurious pressure, but owing to the much greater degree to which the uterus can contract, the interruption to the supply of maternal blood to the placenta is much more complete, yet it is possible for the fœtus to retain perfect vitality for many days after the escape of the liquor amnii, as is shown in the following cases.

Mrs. M., æt. 38, sent for me in June 1878. I found her pregnant with her eighth child. She was in a state of great anxiety on account, as she assorted, of the escape of the waters which she told me had come away in large quantities. Examination did not convince me of the accuracy of her statement and I concluded she had mistaken the source of the aqueous flow; one thing was certain, however, and that was that she was not then in labor, although very near her time. She was enjoined to keep quiet, though rest in bed was not insisted upon. Five days afterward I was again sent for and found her in the first stage of labor, but no membranes could be felt. She was safely delivered of a living child. If the membranes really did rupture at the time supposed, this is the longest period between the rupture of the membranes and the coming on of labor I have met with personally, but the following cases represent the possibility of the preservation of the viability of the fœtus under these unfavorable circumstances for a much longer period. Dr. Matthews Duncan reports a case in the *Lancet*, for June 29th, 1872, in which forty-five days elapsed from the time of the rupture of the membranes to that of the birth of the child. During the whole of this period the liquor amnii continued to escape as it was secreted and the size of the uterus as felt through the abdominal walls was greatly diminished; when labor took place, a seven month fœtus was born and lived for several hours, although much deformed by the protracted pressure to which it had been exposed. In the *Medical Times and Gazette*, for September 18th, 1852, Dr. John Goreld reports a case in which twins, a boy and girl were born, living five weeks after the waters had come away. Although the above cases are well authenticated, especially that of Dr. Duncan, in which the most careful observations were made, yet the asserted escape of the liquor amnii must be always received with great caution. The sources of the aqueous flow which may be mistaken for the liquor amnii are numerous. The spontaneous escape of urine is not infrequently mistaken by the patient for that of the liquor amnii, while the flow of profuse secretions of Cowper's glands; the rupture of a cyst of the chorion; of another developed or undeveloped ovum; of a cyst lying between the chorion and the amnion may prove the source of the supposed liquor amnii. That the membranes may again close after having been ruptured has been proven. This is not accomplished by a process of healing as was at one time supposed, but by the sliding of the different layers of which the membranes are composed upon each other by which a small opening may be effectually closed. After closure of the amniotic cavity in the manner described the liquor amnii again collects, for this fluid is continually secreted as first shown by Winkler and demonstrated in Matthews Duncan's case. A source of error in diagnosis as to the origin of the flow is in rupture of the membranes at a point within the borders of the os and out of reach of the examining finger. Here vaginal examination shows the presence of the membranes closing the os and which became tense during the pain, while the opening becomes patulous and admits of the escape of the liquor amnii during the periods of relaxation. Notwithstanding the occasional occurrence of cases such as I have just given, the usual result of the escape of the waters, at whatever period of gestation it may occur, is to precipitate immediate labor, and this labor as already shown is unusually distressing to the mother and at the same time subjects the fœtus to increased risks. We have seen that the peril to the fœtus is due solely to the persistence or the frequency and violence of the pains interrupting too frequently, too persistently or too completely the supply of maternal blood to the placenta.

The abnormal pains are not alone due to the irritation of the mouth of the uterus by the direct contact of the fœtal parts with the uterus but also to the mental condition of the woman. Most women view the occurrence of rupture of the membranes at the beginning of labor with anxiety and alarm, and such a state of the mind is very apt to be reflected injouriously upon the action of the uterine muscles. Hence care is necessary in the conduct of such labors, first of all to reassure the patient, then to enjoin rest as soon as the pains come on and if they are at all disposed to assume an abnormal character, to keep the woman constantly in bed and give opiates to control the severity of the pains, to preserve the proper rythm of the contractions and favor dilatation of the os.

Before closing this paper I wish to refer to another, though kindred subject. I allude to the obscure symptoms sometimes occasioned in the parturient woman by the presence of intercurrent acute disease.

I have several times been deceived by symptoms due to the malarial poison becoming manifest during labor or in the lying-in period, which have in the one case closely simulated approaching exhaustion, and in the other acute local inflammation. Sometimes the manifestations of the presence of this poison consist of chills followed by fever, while in other cases there is more or less neuralgic pain alone. When the previous history of the patient has been obtained and such history shows the presence of malarial poison, the diagnosis of the true nature of the symptoms is not difficult, but it is so when no evidence of previous symptoms of intermittent fever is attainable. The following case is one of this character. Mrs. C., æt. 22 years, was taken in labor with her first child early in the morning of June 8th. As she had been referred to me for attendance in confinement by her regular medical attendant, I had no opportunity of obtaining a personal knowledge of her previous health. I learned, however, that in so far as she knew, she had never suffered from malarial poisoning. She had, however, suffered very much from almost nausea and frequent vomiting at the beginning and toward the close of her pregnancy. The labor continued throughout the day and in the evening became quite severe. The vertex presented in the first position. As the os dilated but slowly and the patient's sufferings were severe, I ordered her to take a full dose of morphia. An hour or two later her symptoms were not satisfactory; her pulse was beating at the rate of more than 100 per minute, her mouth showed a tendency to dryness, constant thirst existed and the patient frequently vomited bilious matter. Although the uterine contractions were very painful and frequent they were short, weak, and inefficient, when the patient had been over twenty hours in labor, as the os was pretty widely dilated, I decided, in view of the symptoms, to apply the forceps and establish the second stage of labor, believing the physical strength of the patient to be sufficient to safely accomplish the subsequent stage of delivery. She was accordingly etherized to complete unconsciousness and the head of the child brought through the os and down upon the floor of the pelvis. The forceps was then withdrawn. As the effects of the ether passed off, good expulsive pains came on and in due time a living child was born without accident. The mother did well for the first nine days after delivery, although the frequent pulse continued, with much coating of the tongue and some headache, but without any febrile symptoms whatever. On the tenth day, however, while still kept in bed, she was seized with pains in the left iliac region, which on the following day became violent, and did not yield to the small quantity of opium (a remedy which she could not take without very disagreeable symptoms) which I induced her to take. This pain was not accompanied by fever, and I had no doubt was malarial in its origin. Acting upon this belief she was placed upon full doses of quinine, when not only did the pain speedily disappear, but with it the frequent pulse, the headache and the nausea. The patient had come to live in the house in which she

was confined but a few months before her confinement and the first evidences of the malarial poisoning in her system were those which appeared during her labor and subsequent lying in. The dryness of the tongue and much of the nausea appearing during labor were probably due to the opium I had given her.

Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD DEC. 3, 1885.

The President, B. F. Baer, M. D., in the Chair.

SOME CASES OF TARDY FIRST STAGE OF LABOR AND THEIR TREATMENT.*

DISCUSSION.

Dr. Parvin remarked that the subject of Dr. Richardson's paper was one of great practical importance, and his presentation of it has been very interesting. Coming to its ultimate analysis a case of labor, tedious in either the first or in the second stage, shows a want of proper relation between power and resistance; the former for an unusually long time is unable to overcome the latter. Manifestly if this be so, we have naturally suggested to us two plans of treatment, either increase the power or lessen the resistance. These principles are plain, but the selection and the application often present serious difficulties. Severe suffering in the first stage of labor certainly should be relieved, for this suffering exhausts, and it does not follow that the power of pain is to be measured by the intensity of suffering it produces, and therefore "painful" pains are an undoubted evil. As to the means for their relief when they are associated, as they usually are, with very slow dilatation, many would prefer chloral injected into the rectum to morphia internally, or anæsthetic inhalation.

In regard to the process of dilatation of the os, it is possible Dr. Richardson has attached too much importance to the bag of waters as a dilatating means; that is the mere passive process, but there is an active process, that by which the circular fibres of the uterus are, by the action of the longitudinal fibres, retracted over the bag of waters, or the presenting part, if the former be ruptured; it is not so much descent of the presenting part which occurs as it is the ascent of the expanded cervix, for in primiparæ, at least, the head is usually at the beginning of labor in the pelvic cavity, and it can go no farther until the dilated os has passed more or less completely above it. It may be that resistance being lessened by chloral, or opium, the power is sufficient to overcome it, but if it be not, probably the continuous current of electricity will be the most efficient means to increase the uterine force. In this connection I may refer to the statements of Bayer in his recent elaborate menograph entitled, *Morphologie der Gebärmutter*. In many cases of labor where delay occurs in the first stage, it is not the os uteri that is at fault; the obstacle is higher up, and according to Bayer, the anatomical condition of this "*Stricturirung*" is the deficient unfolding of the cervix. In such condition there may be a spastic ring-like stricture or a spastic partial stricture. The first form is especially liable to occur in a narrow pelvis. Bayer recommends warm fomentations, warm vaginal irrigations, a whole bath, eventually narcotics, especially opium by rectal injection, but he strongly insists upon the continuous current as the true natural method of treatment, on the one hand relieving cramp and on the other exciting labor activity, thus removing the primary failure, the deficient unfolding of the cervix. One word as to the occurrence of malarial poisoning in the puerperal woman. I think it comparatively very rare. Certainly this is the conclusion which I must draw from my own experience in private and in hospital practice. In two terms of service at the Philadelphia Hospital I have seen probably forty cases of puerperal septicæmia, and only one case

*See page 157.

of malarial fever. When one sees a febrile attack in a woman after labor, he is disposed to take the most favorable view of the case and may attribute, at first, at least, the disease malarial, when really it is caused by septicæmia, losing precious time, and may be led to give a favorable, when a doubtful prognosis should be indicated.

Prof. Jaggard, of Chicago, upon invitation from the Chair, remarked that morphia hypodermically had been extensively tried in the first stage of labor at Vienna and Paris, and had been discarded in the former city about six years ago, and in the latter more recently. It had been found to affect the fœtus unfavorably. One fourth of a grain administered every four hours for some time would be attended with grave elements of prognosis. The possibility of a live fœtus remaining in the uterus forty-five days after the escape of the amniotic fluid he considered more than doubtful. Cysts sometimes form between she amnion and chorion, and the bursting of one of these may give rise to the idea of the escape of the amniotic fluid. Hydrorrhœa gravidarum, a condition dependent on a diseased condition of the decidua, is a more frequent phenomenon, and will explain many of the cases of supposed rupture of the amniotic sac.

Dr. W. T. Taylor remarked that the causes of delay in the first stage of labor were numerous. For the relaxation of rigid os he would prefer hydrate of chloral, twenty grains; one eighth of a grain of sulphate of morphia every two hours has a soothing and beneficial effect, giving rest and sleep between the pains. When the edge of the cervix is thin and wiry the morphia is especially called for. He has experienced delay from dropsy of the amnion. After a delay of six or eight hours he has ruptured the membranes, and after the escape of an enormous quantity of fluid, rapid and effectual contraction supervened. Another cause of delay is posterior positions of the occiput; if a change of position can be effected labor will progress more rapidly. He has observed premature escape of the liquor amnii from ten days to two weeks before labor, and yet everything went on normally. He has met with one case of malarial poisoning. In the eighth month intense pains were experienced but there was no effect on the os. He gave five grains of quinine and ten grains of potassium bromide, and in a few hours the pain was relieved.

Dr. Longaker stated that according to his experience morphia should be used guardedly. In some cases it has caused still-births. In a recent case the first stage of labor had lasted twenty-four hours, and the os was but one inch in diameter, four doses of sulphate of morphine, one-fourth of a grain each, were by mistake of the nurse, given at intervals of fifteen minutes, dilatation and descent of the child quickly followed. As Dr. Parvin has stated, the early stage of labor consists mainly of retraction of the cervix, and early rupture of the membranes as a trouble is overrated. Undeveloped pelves, of generally small diameter, cause less delay in first labors than in later ones, because in the earlier labors the abdominal muscles are strong to assist the uterine contractions; in later labors, besides having less contractile powers, their laxity allows the body of the child to fall forward and the vertex presents less favorably at the superior strait.

Dr. Trautmann. In one case under his care recently he found a well dilated os uteri and a free escape of waters; the pains ceased, ergot was given without any effect, and as the forceps were strenously objected to, he was obliged to do nothing; after an interval of four weeks labor came on naturally and a living child was delivered. The unaccountable facts in this case are the widely dilated os, the escape of the waters and a living child four weeks later.

Dr. W. S. Stewart. Sodium bromide is useful to prevent premature labor; five drams may be divided into ten doses and one given every three hours. He has observed in one patient an apparent rupture of the membranes at five months, the fluid coming away with a constant drip; later the flow was greatest at night; this condition lasted for six weeks, when it terminated in premature labor, the fœtus was living; the fluid which came away

was examined and seemed to be amniotic. He also has observed retardation of labor from falling forward of the fœtus in relaxed abdomen; when such a patient is placed on her back labor goes on rapidly.

Dr. Chas. M. Wilson remarked that hydrorrhœa gravidarum is more frequent than is supposed, and is mistaken for premature discharge of amniotic fluid. Rigidity of the os uteri is most quickly relieved by inhalations of chloroform. He has found its action more satisfactory than that of chloral and sodium bromide or ether, and safer than morphia. Postural treatment of early stages of labor is of the greatest importance; he would place the patient on the floor on her knees or haunches; holding by the back of a chair or post is often useful as it assists in fixing the respiratory muscles. He has not had good results from the local use of belladonna.

Dr. Keating spoke of some experiments he had been making. The patient was first to practice Dr. Bonwill's method of inducing partial anæsthesia by rapid long breathing for a time and then to hold the breath as long as possible. This method was found to bring on rapid and efficient pains in multiparæ with pendulous abdomen.

Dr. B. F. Baer remarked that, take it all in all, morphia hypodermically is the most valuable remedy we possess for the relief of pain and rigidity of the cervix during the first stage of labor. (Of course, it must be used within proper limits).

Dr. E. Richardson, in closing the discussion, said that his paper was not intended to be comprehensive. His use of morphia extended only to doses of one-sixth of a grain every four hours, by the mouth, and not hypodermically. In the patient, whose history he had given, intermittent fever was developed later on, and he has not the slightest doubt of malarial poisoning being the cause of the untoward symptoms during and after labor; there was no fever, no rise of temperature and, therefore, septicæmia is excluded. There can be no question as to the retraction of the cervix when the head is already in the pelvis; but when the head fits tightly into the superior strait and the cervix is jammed by it, the pressure upon the upper sac is greater than upon the lower, cut off from it by the head. Chloroform is more efficient than any other agent he had used, but it was not always to be preferred.

Dr. Keating exhibited a pair of scissors for denuding flat mucous surfaces; they were remarkably thin. He also exhibited a bivalve fenestrated speculum.

VESICO-VAGINAL FISTULE.

Dr. Keating reported the following case from notes by Dr. Howard H. Pardee. Rebecca Johnson, col., married, was admitted to the Philadelphia Hospital in the summer of 1884, complaining of inability to retain her urine and of a constant bearing down pain in the hypogastric region, a burning pain in the bladder, and of frequent backaches. She had noticed that the urine was sometimes blood-stained in the inter-menstrual periods. She stated that about a year previously she had fallen out of bed and had struck upon a broken chair, one of the rounds of which had entered her vagina, hurting her severely, and that all her symptoms had dated from that accident.

Soon after her admission to the house an operation for vesico-vaginal fistule was performed by Dr. M. B. Musser, which relieved her for a time, but soon all the old symptoms returned. In January, 1885, examination revealed an opening from the vagina into the bladder more than an inch and a half in length, involving the neck of the bladder and the posterior part of the urethra; a pedunculated growth was also found in the bladder, this was removed. The history of venereal disease could be obtained; there was a bad leucorrhœa. In May, examination showed an enormous vesico-vaginal fistula; the neck of the bladder and the urethra had entirely disappeared. The edges of the fistula were very thick and callous, and anteriorly very little tissue was left beneath the pubic arch. A small recto-vaginal fistula was also found and exhibited the same thick rigid edges. Several deep scars were found on the

nymphæ and labia-majora, which seemed to be the marks of healed chancroids. An operation for the closure of the vesico-vaginal fistula was performed November 15, 1885, but the patient died a week later. The specimens, showing the wound closed, were exhibited to the Society.

Dr. B. F. Baer presented the specimens and read the report of a case of

HYDRO- AND PYO-SALPINX, COMPLICATED WITH FOLLICULAR DEGENERATION OF THE OVARIES.

Mrs. H., æt. 42 years, was sent to me some months ago. She complained of great pain in both iliac regions, more in the right, radiating into the pelvis and sacrum and down the limbs. She had menorrhagia, and profuse leucorrhœa during the inter-menstrual periods. She dated the trouble from an abortion which had occurred nine years before, and which was followed by symptoms of acute parametritis from which she never fully recovered. Examination showed the uterus to be considerably hypertrophied and fixed as in a vise by an indurated mass on either side of it, which seemed to occupy both broad ligaments, or to be closely adherent to them. The cervix uteri was also badly lacerated; and its mucous membrane presented a surface so hypertrophied, abraded and jagged, that I was at first strongly impressed with the fear that epitheliomatous degeneration had begun to develop. I pursued a plan of treatment designed to reduce the congestion and hypertrophy of the diseased neck, and at the same time to induce an absorption of the plastic and indurated lymph around the uterus, to render the organ mobile, so that an operation might be made safe. I only partially succeeded, for, while the uterus became much more mobile, there still remained a swelling or tumor on either side of it. These tumors had illy-defined borders, were not circumscribed, but were elongated and rather cylindrical in form, and fixed to the lateral pelvic walls, as well as to the uterus, though not very firmly to either. I now suspected disease of the Fallopian tubes, and probably also of the ovaries. The patient entered my private hospital in February, 1885, when I operated upon the cervix, dissecting away a large quantity of tissue for the purpose of making proper adjustment of the labia and to get rid of the cicatricial tissue. It was not epitheliomatous. I had hoped by this operation not only to restore the cervix to health but at the same time to induce, by a derivative action, a retrograde metamorphosis in the diseased tissues and organs appended to the uterus. I succeeded in the former, and also in modifying all of the symptoms, except the pain in the ovarian regions. This seemed to be made worse, or, at least, to become more prominent as the other symptoms were improved. The patient was sent to her home, and advised to rest in the recumbent position for at least a part of every day. Later, as she did not improve, a local treatment, consisting of an application of the tincture of iodine to the fundus of the vagina, at intervals of a week, with boroglyceride tampons almost daily, at the same time counter-irritation applied to the iliac region by means of blistering, was faithfully pursued. Nothing proved of more than temporary benefit. She began to lose flesh and fail in strength. The fulness at the sides of the uterus had increased. She again entered my private hospital and, under anæsthesia, I determined that the Fallopian tubes were distended to the size of a small sausage, that the ovaries were also enlarged, and that the tubes, ovaries and ligaments were all adherent to one another by plastic lymph. I advised laparotomy for the removal of the uterine appendages; the patient readily assented. A week later I made an incision, three inches in length, through the abdominal wall, fully two inches in thickness, and came upon the omentum, which was also very fat. This was adherent by its lower border to the pelvic tissues and organs, so that I was compelled to dissect it off on the right side before I could reach the uterus with my finger. Everything, Fallopian tubes, ovaries, broad ligaments, uterus, omentum and intestines were so adherent and matted together that it was difficult to differentiate between them. The

tubes were greatly distended and contained, the right, pus, and the left, serum. The fimbriated extremities were glued to the lateral pelvic walls. The ovaries were as large as a good sized hen's egg and were closely adherent to the posterior surface of the broad ligaments. I dissected with my fingers, two being introduced until the right tube and ovary were released, when they were drawn to the incision, ligated and removed. The left tube and ovary were released with still greater difficulty, but I finally succeeded in ligating and removing them. Considerable hemorrhage occurred during the operation, and it was necessary to place a number of ligatures. The abdominal wound was closed with eight silk sutures. The operation occupied more than two hours. The patient slept four hours before she returned to consciousness, and awoke without the slightest nausea, which both she and I dreaded very much from previous experience. There is not much to say concerning the after treatment, for she did not require much. Her temperature never rose above 100°, and she made an uninterrupted recovery. She went home at the end of five weeks, and has been free from the old pain in the iliac region since four days after the operation.

Dr. B. F. Baer also exhibited a

SMALL FIBROID TUMOR WHICH HAD UNDERGONE CALCAREOUS DEGENERATION.

Mrs. L., æt. 60 years, a patient of Dr. J. H. Musser, of Lancaster Co., Pa., has had two children and two miscarriages. She had been treated for uterine hemorrhage a number of times during the past fifteen years. She continued to "menstruate" until she was fifty-seven years of age. One year afterwards she began to suffer from severe uterine tenesmus, which was soon followed by a severe attack of "flooding." After this she had frequent recurrence of the hemorrhages up to the time of the removal of the cause. The case had been looked upon as one of cancer, and had been abandoned to the fate which attends that dread disease; but she lingered on and finally came under the care of Dr. Musser, who found on examination that the cervix, at least, was not cancerous. Through his kindness, I saw the lady at her home in September, 1885. I must confess that when I entered the room, I was almost on the point of quietly saying to the doctor that I believed his patient had cancer. She had a marked cachectic appearance and there was an odor very much like that of cancer. I advised that a thorough investigation be made with the patient under ether. I found the cervix smooth and soft; the os slightly patulous, and there were several mucous polypi hanging from it. There was also a fetid muco-purulent discharge, which seemed to come from the cavity of the uterus. I removed the polypi and then carefully passed the sound into the uterine cavity; it was large and filled with numerous soft bodies, vegetations, except at one point at the fundus. Here a mass was detected, which was as hard as marble and gritty. I next dilated the cervix with my steel dilator, which was easily done because the tissues were so soft and dilatable, and passed my finger into the cavity. The finger confirmed what the sound led me to infer. I now removed with the dull curette all of the fungous vegetations; enough to fill a large spoon in the aggregate, and then again introduced my finger and found that the hard mass was imbedded in the uterine wall and pedunculated. I endeavored to remove it with my finger but failed, I then pried it out of its nest with one blade of a polypus forceps. It proved to be a fibroid tumor which had undergone calcareous degeneration. I cauterized the entire surface of the uterine cavity with fuming nitric acid. The patient has had no hemorrhage since. The cure is valuable scientifically, because it shows the fallacy and danger of neglecting cases of metrorrhagia; first, on the theory that the hemorrhage is due to the change of life and therefore physiological; and, second, on the supposition that because the hemorrhage came on so late in life it must necessarily be the result of malignant disease and be permitted to run its course unmolested. Untold suffering and loss of life has resulted from this

want of action. I have so recently expressed my views on this subject in a paper on "the significance of metrorrhagia recurring about and after the menopause," *American Journal of Obstetrics*, May, 1884, that I refrain from further comment here.

Dr. Parvin remarked that in any case of uterine hemorrhage a careful examination should always be made. Hypocrates was the first to record the passage of stones from the vagina. From one patient under his care he removed forty tumors of this calcareous character. To illustrate the difficulty of arriving at a correct diagnosis he related the case of a lady who had applied to him for the relief of an ovarian pain; she was elderly and was the mother of three or four children. A year after he had first seen her the pain had left the ovary and was then in the uterus; finally, a needle was discharged spontaneously from the vagina and the pain disappeared.

Dr. Chas. M. Wilson could not understand how Dr. Baer could make out his diagnosis in the case first described, with two inches of fat in the abdominal wall. How could slightly enlarged ovaries and tubes glued down by lymph deposits be detected? He felt sure he could not do it himself.

Dr. Parish said the diagnosis of such cases is at all times difficult, but the history of the case, with the aid of the examination, will make the diagnosis almost certain, sufficiently so to warrant an exploratory incision. Calcareous degeneration, in fibroid uterine tumors in old women, is frequently found in post-mortem examinations. The calcareous mass may be as large as a child's head.

Dr. Baer, in closing the discussion, remarked that the great difficulty of making a diagnosis was an inducement to present the case before the Society. He had been eight months in making the diagnosis, and, finally, operated with hesitation and many misgivings. The pains were chiefly ovarian, but at first he contented himself with repairing the cervix and endeavoring to promote absorption of lymph deposits, and although there was improvement the ovarian pain remained. When the patient returned the cylindrical mass on the left side was two inches in diameter and could be outlined per vaginam; the ovary was as large as a hen's egg. This I could determine by examination under ether; and on the right side a hard tumor could be felt. This proved to be the thick walled tube filled with pus; it was circumscribed and attached to the broad ligament. I felt sure about the diagnosis, but the adhesions made me hesitate long before yielding to the desire of the patient for an operation.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD DEC. 4, 1885.

The President, DR. L. MCL. TIFFANY, in the Chair.

Dr. S. T. Earle read a paper on

TUBERCULOUS ULCERATION OF THE RECTUM.*

Dr. R. B. Morison asked if Dr. Earle had ever noticed any lupus ulcerations about the anus.

Dr. Earle replied he had not; tuberculous ulcerations about the anus were very rare; he had seen several ulcerations of this character just within the anus on its mucous surface, but never on the skin surface.

Dr. W. T. Councilman considered lupus a very rare disease. He called attention to a point in Dr. Earle's paper that he took to be of considerable interest—that we should find a condition in the intestine entirely analagous to that in the lung; he referred to the presence of caseation and tubercle bacilli without any truly formed tubercles. He said, as the condition is often found in the lung, he thought it would be advantageous if some more expressive name than tuberculosis could be substituted for this particular condition.

Dr. N. G. Keirle asked if erythematous or butterfly lupus was a true lupus.

Dr. R. B. Morison thought not, as he

*See MD. MED. JOURNAL, Dec 12, 1885.

had never found the bacilli present in them.

Dr. L. McLane Tiffany considered Dr. Earle's paper of much importance, as it is, so far as he is aware, the first publication in English, of a series of systematically conducted histological examinations of tuberculous ulcerations in the rectum. He has seen many cases of rectal ulcers, some of them, he doubted not, were tuberculous in character, but they were not diagnosed as such, because he did not then possess the means of doing so. He considered them very difficult to treat satisfactorily. He relieved, without curing, by splitting them clear through.

Dr. E. Meierhof then read a paper on

FOREIGN BODIES IN THE VITREOUS.

He was led to make these remarks by a case in his own practice. It occurred in a boilermaker, who received into the upper and outer ciliary region, about 2 m. m. behind the sclero-corneal margin, a flat scale of steel weighing about 68 m. g. and of an area of about 3x5 m. m.

When he saw the patient there was quantitative perception of light; he suffered but little pain, and the tension of the globe was much reduced. At the point of injury a bit of iris prolapsed. The patient was ordered a one per cent. solution of sulphate of atropia to be dropped into the eye and iced pledgets of lint to be applied locally.

On the third day after the injury he discovered within the injured eye, a dark-looking, movable body, just below and immediately behind the lens. The vetreous he found to be clearer, the prolapsed iris reduced, and the tension much improved.

Upon discovering this body an operation for its removal was at once advised, and was performed on the tenth day after the accident, in the following manner:

A four per cent. solution of the hydrochlorate of cocaine was instilled into the conjunctival sac in the usual way. As the position of the foreign body, when at rest, was on a plane parallel to the plane of the iris, it was thought best to make a scleral incision in such a way as to produce the least disturbance of the contents of the eye. This incision, about 5 m. m. in length, was made on the outer portion of the globe, about 4 m. m. behind the sclero-corneal junction, with a Von Graef cataract knife. The tip of the permanent magnet was then introduced into the opening; it at once attracted the body to it and thus enabled the operator to seize it with a fine clot forceps. It was found impossible to draw it through the opening already made. The incision was then increased in length and a second attempt made, which resulted in successfully removing the body above described. The incision when finished was about 6 m. m. in length. It was closed by a single deep conjunctival suture, which was sufficient to keep the edges of the wound in apposition. The writer stated later that he thought he could have had slightly better union by two instead of one suture. There was practically no hemorrhage, but there was considerable pain, the cocaine seeming to be effectual only in permitting painless manipulation of the conjunctiva.

The patient was kept in bed in a darkened room, and received, at night, a quarter of a grain of morphia sulph. to assure sleep. Improvement was marked, so that at the end of three weeks his vision in the injured eye was $\frac{20}{40}$ or half that of the uninjured one. The eye, never from the time of the accident, recovered its normal tension.

Two months after the operation the patient appeared complaining of loss of vision in the eye operated upon. Ophthalmoscopic examination revealed his trouble to be complete detachment of the retina.

The writer referred to a valuable paper published last June by Professor Hirshberg of Berlin, in which he points out many valuable indications to be observed in treating cases of foreign bodies in the vitreous. He also makes some valuable suggestions as to apparatus necessary in these manipulations.

Dr. A. Friedenwald thought the electro-magnet, as introduced into surgery for use in these cases, merited all the advancement it had gained. Formerly

the great trouble in these accidents was the difficulty of locating the foreign body, and then the risk of not properly making your incision, but the magnet has overcome this. He thought if the eye could be saved, even though vision is lost, that we had gained a great advantage, for the reason that an artificial eye, aside from inconvenience, will give rise to painful and troublesome catarrhal ophthalmia.

Dr. E. G. Waters said, in speaking of the magnet in eye practice, he thought it of historical interest to state that Dr. Bailey, of Cambridge, Md., a former president of the Medico-Chirurgical Faculty of this State, had used the magnet about 45 years ago to remove a a bit of steel from a boy's cornea.

Dr. Friedenwald thought a skilful manipulator should be able to remove foreign bodies from the cornea by the use of a cataract needle.

Dr. Samuel Theobald thought incisions parallel to the circumference of the cornea much more apt to gap and cause loss of vitreous, than if they were made in the opposite direction. Beside this, in such an incision you were much more liable to interfere with the ciliary nerves. Dr. Meierhof had made, in his own operation, an incision parallel to circumference of cornea and had practically no loss of vitreous, nor injury to the ciliary nerves.

A CASE OF NEW POST-MORTEM INSTRUMENTS.

Dr. W. T. Councilman then exhibited a case of instruments devised by himself and used in making post-mortem examinations. Aside from the usual instruments necessary in this work he called attention to the method that he has adopted for removal of the spinal cord. It consists in cutting through the laminæ of the vertebræ with an instrument similating a miniature butcher's clever. The cutting is done by holding the edge of this tool on the lamina to be cut, and striking upon the back with an ordinary hammer. The method is expeditious and after a little practice very free from danger to the cord. The knives that he prefers are large and heavy.

Dr. L. McLane Tiffany thought the same method for removal of the cord was used by the French, as all French cases contained an instrument similar to the one described by Dr. Councilman.

ADENO-CARCINOMA OF THE OVARY.

Dr. N. G. Keirle showed a large growth removed at autopsy from a female. It was an abdominal tumor, nodular and slightly elastic. The uterus (that of a virgin) lay on the anterior upper aspect of the growth. Histological examination revealed the mass to be an adeno-carcinoma of the ovary.

Dr. A. F. Erich gave the clinical history of the case. She was sent to him and represented to have an ovarian tumor. Upon examination he found a nodular growth, completely filling the pelvis, immovable and extending up to the umbilicus. It gave no sensation that would lead one to suspect a multilocular cyst. This mass, gravitating into the pelvis behind the uterus, caused the organ to ascend to such a degree that it was with much difficulty that the os externum could be reached by digital examination. When she entered the hospital her temperature was 103° F. The fever continued and pain was constant. With these symptoms, and from what he could gain by exploration of the pelvis, he took it that the woman was suffering from pelvic peritonitis, and the ascent of the uterus was due to exudation into and swelling of the post-pelvic tissues. He had seen the uterus ascend from such a cause. She was put upon therapeutic treatment and after one week she died. He questioned the possibility of a diagnosis having been made ante-mortem. The clinical history certainly did not, in his mind, point to the existing condition. Had he suspected cancer, his suspicions would not have been fortified by the presence of peritonitis as is usually the accompaniment of these trouble. He did not try the knee-chest position in order to dislodge the growth, because it was so absolutely immovable that he did not suspect a mova-

ble tumor. Even though a diagnosis had been made, he doubted the advisability of an operation.

Dr. N. G. Keirle said the retro-peritoneal glands were enlarged and showed metastices from the cancerous centre. Death was caused by thrombus in the pulmonary artery.

SPECIMENS OF ULCERATED INTESTINE.

Dr. N. G. Keirle showed a portion of an ulcerated intestine. The diagnosis involved some difficulty. The question arose, whether the ulcers were tuberculous, typhoid or dysenteric. The lungs were not at all affected. The liver was studded with caseous masses not broken down. He inclined to the dysenteric origion of the ulcers because he had found groups of small, round, darkly stained bodies in the interlobular vessels of the liver which he thought pointed to this opinion. He took them to be micrococci in masses. There were ulcers in the rectum which he could not say were of tuberculous or septic origin.

Dr. W. T. Councilman thought the ulcers in the intestine dysenteric; and the processes in the liver metastatic abscesses.

Dr. L. McLane Tiffany thought the subnormal temperature, as shown by the clinical history, indicated epidemic dysentery, and at the same time excludes both tuberculosis and typhoid. Moreover, the anatomical appearance of the gut was that of dysentery, and he should say that the absence of the intestinal discharges for a few days before death, as shown by the clinical history, was due to inability on the part of the patient, to empty the bowels.

Dr. J. W. Chambers doubted the accuracy of the thermometer used in taking these temperatures, for he could not conceive of such a condition of the liver and intestine and a subnormal temperature.

Dr. L. McLane Tiffany said the clinical record of undoubted cases of epidemic dysentery all showed subnormal temperatures.

Dr. I. E. Atkinson thought the subnormal temperature in acute dysentery and in acute abdominal inflammations, due to the subtraction of blood from the surface by hyperæmia of the abdominal vessels. He called attention to the enormous distribution of blood vessels in the abdominal cavity, which dilated, as in hyperæmia, must necessarily lessen the quantity of blood in the surface vessels. He supported his view by relating a case of acute abdominal hyperæmia, which gave a subnormal surface temperature and which showed, when the thermometer was introduced into the rectum, a temperature of 104° F. This is not the case in chronic abdominal inflammations.

Dr. J. H. Branham thought that in the case under discussion the number of abscesses in the liver might have been a cause for the reduction in temperature by their presence interfering with the normal heat producing function of the liver.

TREATMENT OF ACUTE RHEUMATISM.—Dr. R. H. Fox states in the *British Medical Journal*, October 10, 1885, that in a severe case of rheumatism in which salicylate of sodium, potassium, quinine, colchicum, and liniments had all failed to relieve the fever and pain, the relief was immediate after sponging with cold water and quickly drying the skin afterward. Although this is no new treatment, it is one which requires some courage to practice, and yet may be well adapted to certain severe cases in which the salicylic remedies are ineffectual.—*Ther. Gaz.*

ANTIPYRINE. — M. Dumolard gives preference to the following formula: Antipyrine, 20 parts; Jamaica rum, 30 parts; syrup and water, each, 150 parts. In typhoid fever he gives a teaspoonful three times a day.—*New York Medical Journal.*

The royal medal of the Royal Society has been presented to Professor Lankester, in recognition of his important researches during a series of years on embyology and other biological and zoological subjects.

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BALTIMORE, DECEMBER 26, 1885.

Editorial.

A RETROSPECT OF THE YEAR 1885.—All along the journey of life positions are reached from which the traveller may look back over trodden footsteps to review the progress made. The retrospect may serve the double purpose of strengthening his faith in achievements won and his courage for those ahead of him. The sum of human endeavor is measured by the results of efforts expended and the forces in reserve for subsequent outlay. Thus, by contrasting the work done with that which awaits him, one is prepared to renew his energies for duties ahead.

At this season of the year it is eminently proper that professional workers should take stock of the year's returns. What have I done and how stands my stock in trade at the end of the year? This is a pertinent question for each one to ask. It is not to be presumed that each one is prepared to give a favorable answer to such an inquiry. It is too true that the professional hive contains its drones; but, as a rule, the medical profession is remarkable for the energy, activity and untiring industry of its many members. Whether impelled by force of necessity, habit or inclination medical men, as a class, do vast sums of labor and achieve important results, whether measured by the standard of their services to the sick, to their professional interests, or to science. The medical profession has a record for its humane and beneficent labors which, when measured by the standard of its usefulness to society, places it in the highest rank among human avocations. It is a record of which each physician, however humble his sphere may be, should feel that he has had a part in making. No higher spirit should actuate a physician than the consciousness of knowing that he has worked faithfully and earnestly in professional duty and that he has contributed to the alleviation of suffering humanity. It may not be reserved for each member of the profession to add largely to the stock of scientific knowledge or to write his name among the great men in science, but each and every practitioner of the healing art is in duty bound to contribute his mite to the perfection of the entire system of scientific results. In the development of scientific progress it is the multitudinous host of individual skilled observers who must flood the world with precise individual observations. The age in which we live is one of intense criticism and experiment. It is within the power of the individual to aid in this work of precise observation and test. The science and the practice of medicine are undergoing a state of transition. The immense mass of accumulated knowledge is as yet a heterogeneous pile of rubbish in which the facts of medicine are hidden and from which they must be gleaned by the united labor of many individual workers.

Looking back over the progress of the year the profession has much to encourage it in its earnest labors. The year has been by no means an idle one. In each department of the science practical results have been presented which have added to the fund of accumulated facts. Looking over the literary field we observe a great display of literary effort in book-making, in compilations, and in journalistic efforts. The year has introduced to the profession several medical works of decided value, which appear in print for the first time, whilst new editions of well-known works vie with their new competitors. It seems to

us that more than the usual number of monographs has appeared during the year. Among the Journals several new publications have entered the field for professional favor, whilst several which were once known to fame are now known only in deed not in name. In the department of surgery the use of antiseptics has been a favorite subject for discussion, and, at the present time of writing, the bi-chloride solution holds the vantage ground. Anæsthetics have not fallen into disrepute or lost in interest. Local anæsthesia has attracted well-merited attention and gives promise of encouraging results. In operative surgery deep interest has centered upon the various procedures within the cavities of the body. A triumph was recorded early in the year in the removal of a glioma from the cerebrum. The abdominal cavity has been ruthlessly invaded by the scalpel with results which astonish the imagination. The record of the year in abdominal surgery cannot be excelled in achievements by any other character of medical or surgical work.

In the practice of medicine antipyretics have received a large share of attention and criticism; whilst materia medica and therapeutics have brought to notice several agents which further investigation may deem worthy of a permanent position among the resources of the healing art.

The epidemic of cholera in Southern Europe has kept up the interest in bacteriological studies and led to the introduction of conflicting theories in regard to the etiology, prevention and treatment of this disease. The practical outcome of this study has been a thorough investigation of disinfectant agents, and an increase of confidence in disinfection and cleanliness as the means of combatting the disease. Marked attention has been given to sanitation throughout the large American and European cities during the year with a practical result in the reduction of the death-rate from all zymotic diseases. Whilst our own country has been spared the horrors of the cholera scourge, which devastated Southern Europe, and of the small-pox epidemic which has decimated our neighbors in Canada, the Plymouth epidemic has fallen upon a small community with such power as teach the importance of attention to the local sanitary condition of all small towns and cities.

The year records the usual number of deaths in the profession. Many honored and esteemed laborers in professional work have entered into the rest prepared for the just, leaving behind the memory of their lives and deeds, and the admonition that the harvester is ever near at hand to gather in the golden blades. The births into the profession have exceeded its deaths. Each year the profession is reminded of the loose and irregular methods which pervade our educational systems. We are unable to record any satisfactory progress in the direction of correcting an evil which is sapping the vitality and influence of professional usefulness in our country. A few of the States have succeeded in securing the passage of laws regulating the practice of medicine within their borders. In Pennsylvania, Virginia and West Virginia a much needed system of protection has been secured.

The record of the year has been marked by a controversy on the subject of the International Medical Congress which has been a humiliating spectacle to the fair-minded members of the profession. We have witnessed an upheaval of demagogism and petit jealousy which should find no encouragement in professional opinion. The differences which have divided the profession on the Congress controversy have been unwise and unnecessary. They have taught no important principle of ethics, and have cast lasting discredit upon the fair name of American medicine.

We have freely expressed our views on this subject in the interest, we believe, of scientific medicine and not out of consideration for the ethical points raised. Ethics are rules of conduct, not theoretical trueisms which have no force in action. The science of human duty is broad, liberal and tolerant, not a fixed code which prescribes opinion by rules more rigid than the Inquisition.

We cannot close our remarks without

turning attention to the faithful work in progress in France, in the laboratory of the eminent bacteriologist, M. Pasteur. The old year may ring out before the practical value of M. Pasteur's experiments have been fully demonstrated, but we may look to the year upon which we are about to enter for the full realization of the fact that in the line of bacteriological investigation we have the promise of the most important achievements which science can render to humanity.

Miscellany.

The Mitral Cardiac Murmurs.—The study of the mitral cardiac murmurs at the present time is of importance to every medical practitioner, as well as of interest to those whose attention is especially directed to the diseases of the heart. In an able article in the January number of *The American Journal of the Medical Sciences* Dr. Austin Flint reviews our existing knowledge of these murmurs. He holds that there are four mitral murmurs, namely, (1) the systolic regurgitant, (2) the systolic non-regurgitant or intraventricular, (3) the presystolic, and (4) the diastolic. Each of these four murmurs has distinctive characters which individualize it. Two, three, and even all four may be combined in the same case. This statement, as will be seen, applies to the systolic regurgitant and to non-regurgitant murmurs. The names post-diastolic and post-systolic, proposed by Hayden, seem to the author unnecessary refinements, and, therefore, objectionable. If the reader would stop to reflect upon the inquiry whether the mitral murmurs offer topics for consideration and discussion of sufficient interest and importance to occupy the thirteen and one-half pages which Dr. Flint devotes to them, let him refer to that portion of the elaborate and able work on diseases of the heart, by Hayden, which treats of the cardiac murmurs. He will there find a statement of the defects in our existing knowledge, together with differences of opinion in regard to the number of the mitral murmurs, their characters, their significance, and the modes of their production, which must convince him that they afford scope for an article extended much beyond the limits to which the author restricts himself. In fact, the object of the article is to present certain conclusions and suggestions without attempting to consider the subject comprehensively and fully.

Imperfect Symmetry.—Few things in nature appear more constant and exact than that symmetry of organic form which is shown in the likeness of the several members of each two or more corresponding and similarly useful parts. The example nearest to each of us is the symmetry of the two side-halves of his own body; it usually appears perfect. And, so far as it can be tested by chemical analysis, or by the much more delicate indication of symmetrical disease, there is a symmetry of composition as well as of shape and visible structure. In substance, as in form and size, the two halves appear exactly alike. And yet, as Sir James Paget points out in the January number of *The American Journal of the Medical Sciences*, it is probable that their symmetry is never quite perfect. Sir James thinks that any one who will carefully compare the two or more similar component parts of himself, or of any animal or plant, or any bilateral organ of either, will find, within the general likeness, some unlikeness of size or form, of texture or color, or of all these together. Certainly it is so in the two lateral halves of our own bodies. Just as between parents and offsprings, the likeness is general and constant, but never perfect, so is it between the halves of each individual. Invariably nature varies. The phenomena of symmetrical diseases, to which attention was drawn many years ago by Dr. William Budd and Sir James Paget, are now carefully studied by many; but those of the modifications of disease associated with the defects of symmetry need study, too. Sir James states that he constantly observed them during many years, but has made no exact records of them, and can, therefore, do little more than suggest some of the

lines of study which may yield to others better results than he has gained. The study should include the defects of symmetry or similarity, not only of size and shape, but of composition and of rates and methods of development, degenerations, and disease. These are too often dismissed from study when they are called "exceptional cases," a mischievous pharse if it be deemed explanatory; for it is probable that an "exception" to one rule is only an example of another rule which is as yet unknown.

Ozoniferous Essences as Antiseptics.—Listerine possesses essential properties analogous in their effects to the ozoniferous ethers so highly recommended by Dr. Benjamin Ward Richardson and others as deodorizers and disinfectants for the sick room, and should be used in the same way—sprinkled over handkerchiefs, garments, and the bed-linen of fever cases. Mantegazza, "On the Action of Essences and Flowers in the Production of Atmospheric Ozone, and on their Hygienic Utility" (*Rendiconti del Reale Instituto Lombardo*, vol. iii., fasc. vi.), as quoted by Fox on Ozone, reports that the disciples of Empedocles were not in error when they planted aromatic and balsamic herbs as preventatives of pestilence.. He contends that a large quantity of ozone is discharged by odoriferous flowers, and that flowers destitute of perfume do not produce it. Cherry-laurel, clover, lavender, mint, lemon, fennel, etc., are plants which develop ozone largely on exposure to the sun's rays. Among flowers, the narcissus, heliotrope, hyacinth, and mignonette are conspicuous; and of perfumes similarly exposed, eau-de-cologne, oil of bergamot, extract of millefleurs, essence of lavender, and some aromatic tinctures. He also points out that the oxidation of the essential oils, such as nutmeg, ani-seed, thyme, peppermint, etc., are convenient scources of ozone, and concludes that the ozoniferous properties of flowers reside in their essences, the most ozoniferous yielding the largest amount of ozone.

It is of such aromatic essences that Listerine is composed, and hence its efficacy under the circumstances indicated.—*The Sanitarian*, Nov. 1885.

Toxic Action of Cocaine.—Dr. Zeim, of Danzic has communicated to the *Allgemeine medicinische Central Zeitung* the notes of a case, in which he applied two drops of a four per cent. solution of cocaine to the eye of a man, aged 40. In a few minutes, after the pupils had become dilated, the patient's face became pale, sweat broke out on his forehead, and his breathing become embarrassed. Dr. Ziem at once loosened his clothes and opened the window, but it was a quarter of an hour before he could return home. The man's wife said that he had not previously had syncope. He was of intemperate habits, and some years ago had been treated for disturbances of motor power in the lower limbs, apparently connected with syphilis. Dr. Ziem says that seventeen cases have been recorded in ophthalmological literature in which toxic effects followed the use of cocaine. In three it was injected hypodermically, and in fourteen dropped into the conjunctival sac. The cases have been described by Peck (1), Mayerhausen (1), Stevens (1), Reich (2) Knapp (3), Heuse (4), and Bellarminoff (5), In some cases the symptoms have been transient, consisting of pallor of the face, giddiness, and sweating of the face or neck; in others there have been dyspnœa, great feeling of prostration, malaise, and apathy, lasting sometimes for several days. Vomiting and headache have been rarely present. In one case, the application of fifteen drops of a two per cent. solution to the conjunctiva was followed by tottering gait, difficulty of speech, confusion of the mind, and extraordinary restlessness; and, in another, the subconjunctival injection of about eight drops of a 3.5 per cent solution produced convulsions and loss of consciousness. The strength of the solution used was 4 per cent. in eight cases, 2.5 per cent. in four, and 2 per cent. in three or four others. The quantity generally varied from two to four drops. The subjects were, in some cases, feeble,

aged women; in others, they were strong and healthy individuals, both male and female.—*Brit. Med. Jour.*, November 21, 1885.

Modern Medicine of the English-speaking Race.—In the opening article of the January number of *The American Journal of the Medical Sciences* Sir Henry Acland presents a philosophical survey of the "Modern Medicine of the English-speaking Race," and referring to the new international character of the *Journal*, he says: Some apology is offered to science for the assumption that there is room for a scientific journal with the apparent restriction to one language and one human stock. Science has no restriction and a universal brotherhood. But science has her votaries everywhere, and every language can contribute its share. The present endeavor is to offer to those who seek it, a means of hearing a message from English-speaking people, who, apart from politics of every kind, may gather results profitable to medicine, learnt from types of every climate of the globe, from very many races of the most diverse origin, and from every occupation and every condition in which the human family is engaged.

Hygiene and Bacteriology.—The German Government has ordered that chairs of hygiene and bacteriology be established in all the Universities of the Empire.

Medical Items.

The distinguished German surgeon, Volkmann, of Halle, has been created a noble by the King of Prussia.

Sir William Jenner and Mr. Erichsen have been made foreign honorary members of the Belgian Medical Academy.

Dr. Rabuteau, so well known during the past twenty years by his original work in physiology and experimental therapeutics, is dead.

The four children forwarded from Newark, N. J., to the laboratory of M. Pasteur in France, have arrived safely at their destination, and on the 21st were inoculated with the virous prepared by the eminent bacteriologist. At the date of writing they were reported as doing well.

The diploma of Honorary Member of the Royal Medical Society of Munich, handsomely illuminated on vellum, was sent last week to Sir William MacCormac. This distinction was unanimously voted at the instance of Professor von Nussbaum. The diploma bears the signature of Dr. Lotzbeck, Surgeon-General of the Bavarian Army, President.—*Brit. Med. Jl.*

Professor John C. Draper, the well-known chemist, physician and scientist, died in New York City, on the 20th of December, after an illness of two days. Professor Draper was born at the University of Virginia, in March, 1835. He graduated from the Medical Department of the University of New York in 1856, and since then has occupied many positions of honor and trust as a teacher, practitioner and author. His latest work, on medical-physics, was recently noticed in this Journal.

A few days ago, an old woman died at the age of 125. She was known for many years as the centenarian of Royannais. Everyone who went to the mountains of Pont-en-Royans visited "Mère Girard." She had out lived all her family. She earned her living by selling her own photographs. Her diet, during many years before her death, consisted of several small glasses of brandy daily, and soup. All the octogenarians of the country say that, when they were children, Mme. Girard had grown up sons and daughters.—*Br. Med. Jl.*

Gasparini (*Gazz. Med. Ital.*) gives 15 cases of neuralgia cured by sulphide of carbon. Ten or twelve drops of the liquid are poured on cotton wool and applied to the painful spot; in a few minutes this gives rise to a burning sensation, but does not blister. The smell of the sulphate is masked by essence of peppermint. The relief resulting from the application of the sulphide of carbon is probably due to its effect as a counter-irritant. *Dolor major minorem solvit* is the explanation of its action.—*Lon. Med. Record.*

Original Articles.

SOME POINTS IN THE MANAGEMENT OF NORMAL LABOR.*

BY E. E. MONTGOMERY, M. D., OF PHILA.

It is not so much the purpose of the writer to endeavor to present something original, as to re-survey old territory in the light of modern investigation and experience, and establish new landmarks for future guidance.

That labor is a physiological process, there is no questioning, but one so modified by our present civilization as to require, in the vast majority of cases, intelligent supervision to bring it to a satisfactory conclusion.

Dilatation of the Genital Tract.—One of the first problems that confronts the attendant, especially with the primipara, is how to accomplish the complete dilatation of the entire genital tract without injury to any of its parts; a problem, the solution of which involves, in a great measure, the future health and comfort of the patient. The partial accomplishment of this process may result in laceration of the cervix, uni- or bilateral, laceration of the vagina, separation of the latter from its attachments to neighboring organs, thus producing as sequelæ, relaxed and prolapsed vaginæ, cystocele, rectocele, etc., laceration of the vulva or perineum. Some of these lesions are very frequent in labor, and by their influence upon the subsequent processes of involution and convalescence, entail untold discomfort and suffering upon the victim. With the knowledge of the production of these injuries, and their evil consequences, it behooves us to study the process of dilatation and preserve the forces nature has provided to this end. The first, and most important to be considered, is the bag of waters. Under the influence of the uterine contractions, the uterus assumes a globular shape; as it contracts upon its fluid contents, the lower segment, decreasing progressively in thickness toward the os, affords the least resistance, and a bag of waters is forced against and into it with each contraction, dilating it by hydrostatic pressure.

This membrane becomes tense and relaxes with each contraction and relaxation of the uterus, until the os reaches a diameter of $3\frac{1}{2}''$, when it remains tense. The membranes are then generally considered to have fulfilled their purpose, and rupture is advised, if it has not occurred spontaneously. On this point Lusk says,* "Something may be done in the way of shortening labor by puncturing the membranes as soon as cervical dilatation is completed. They have then fulfilled their physiological mission and their persistence simply retards the progress of the child's head." Playfair says,† "When once the os is fully dilated the membranes may be artificially ruptured, if they have not broken spontaneously, for they no longer serve any useful purpose, and only retard the advent of the propulsive stage." It is, however, sometimes difficult to determine the complete dilatation of the os. How often is it the experience of the obstetrician to rupture the membranes at this point of apparent complete dilatation, to find a rigid os contract before the fœtus, to be slowly and painfully distended by the unyielding head. This would be avoided should we follow the advice of Blundell,‡ when he says, "In general, commit the rupture to nature;" or Moreau, saying, "Better is rupture late than too early."

But is it necessary the membranes should be ruptured? May they not still serve a useful purpose in the further dilatation of the vagina and vulva?

By rupture of the membranes, as is the common rule, we still have the undilated vagina and vulva to overcome, and with a hard and unyielding body. The vagina is often pushed in folds before the head, while the pressure, besides endangering the vitality of the parts pressed on, interferes with the venous circulation of vulva and rectum, adding to the probability of distress from hem-

*Read before the Philadelphia County Medical Society, Oct. 14, 1885.

*Midwif., 1st ed., p. 205.
†Midwif., 3d Am., ed., p. 278.
‡Midwif., 1840, p. 102.

orrhoids during convalescence, and increases the danger of laceration in the engorged tissues of the vulva and perineum.

H. T. Byford* has shown the importance of preserving the membranes. After the completion of the dilatation of the os, the process of labor is not arrested, as some authorities would have us believe, but the contractions of the uterus separate instead of stretch the membranes, so that the bag precedes the head into the vagina and through the vulva, dilating the entire canal and preventing a thin membranous perineum being caught before the child's head. The membranes may be ruptured before the head emerges, so that the child shall not be strangled in the water.

During the first stage of labor the patient is usually directed to sit up or walk about. Such a course, however, increases the tendency to rupture, hence she should be kept lying down, and when the pains are severe and frequent they should be abated by tinct. op. deod., by mouth, or morphine hypodermically. Besides modifying the severity of the pains and relieving the nervous irritability of the patient, opium renders the cervix more readily dilatable and thus expedites the labor. When the os becomes so dilated as to render the membranes tense, it is better to place the patient upon the back, so the head may fall against the os and assist in the dilation.

In spite of every precaution the membranes may spontaneously rupture. When such occurs nature may be imitated by distending the vagina with an inflated gum bag, or Barnes dilator, or the vulva and vaginal outlet may be dilated, as Mossmann† suggested, by drawing backwards upon it with two fingers inserted into the vagina with each pain.

Anæsthesia.—The necessity and advisability of administering anæsthetics in normal labor is still a mooted question. It is not that the severity of the pains in the second stage are depreciated, for they have been spoken of as affording "distress beyond description," to which was applicable no other name than "agony;" but most probably, for want of a safe and convenient anæsthetic. Chloroform has been most frequently given. It is generally regarded as free from danger, when administered to the parturient woman, but cases are on record of death in labor after inhalation of small quantities of this drug.

Profound chloroform narcosis arrests both voluntary and involuntary contractions. It is, however, only necessary to administer it with the advent and during the pain, allowing the patient to recover consciousness in the interval; but even so administered, there is a feeling that it decreases the power of the uterine contractions and increases the tendency to uterine inertia and post-partum hemorrhage. Still these disadvantages are not so significant as to outweigh the advantage of relief from pain, were we not under the ban of the not unfrequently fatal cases in surgical practice.

Although ether is generally preferred in surgical practice, for its greater safety, it is less desirable in obstetrics, because the control of the patient is diminished unless she is profoundly etherized. Its inflammability makes its use dangerous in a close room at night. Tait* directs attention to the fact that ether rapidly enters the fœtal circulation and increases the peril of the fœtus. He says this danger was indicated by Simpson.

We have in the bromide of ethyl the ideal anæsthetic for obstetrics. It is safe, acts quickly and is rapidly eliminated. It produces no deleterious effects upon either mother or child. It is administered by pouring a few minims to a drachm upon a folded napkin and holding it over the face of the patient with the advent of the pain, removing it as the latter ceases. The pain of the second stage of normal labor may be thus abrogated, without at any time interfering with consciousness. The patient is capable, throughout, of co-operating with her attendant, or withholding her efforts,

*Functions of the Membranes in Labor. *Chic. Med, Journ. and Exam.*, 1885, i, 226.

†Prophylactic Dilatation of the Vaginal Orifice During Labor, as a Prevention of Laceration of the Perineum. *Am. Journ. Obstet.*, 1880, xiii, 563–567.

**Brit. Med. Journ.*, vol., ii, 1880, p. 845.

as may be required. It does not decrease the power of the involuntary contractions, while it materially increases the power to render voluntary aid by removing the fear induced by pain. The writer* has used it, with few exceptions, in all cases during the last two years, without observing any unpleasant results from the practice.

Prevention of Laceration of the Perineum.—Where the membranes are preserved unruptured until the vulva is dilated and the head about to emerge, the probability of perineal laceration is extremely slight. It is not intended to consider the question further, here, than to direct attention to the excellent plan for preventing this lesion, suggested by McGaughey.† It consists in placing the patient upon her left side, with a good-sized roll between the knees. The attendant sits upon the bed at her back, passes the left hand over the abdomen, between the limbs, and with the fingers smooths the scalp and draws the head forward as it emerges from the vulva. The right hand may be used to note the progress, or when the perineum is well distended, to expedite the delivery, by placing the fingers and thumb on either side the anus, against the protruding mass, *i. e.* grasping the child's head, enveloped by the perineum and pushing it forward. The left hand holds the head away from the tendinous centre of the perineum while the right extrudes it, at the same time reinforcing the centre by crowding toward it from the sides.

Delivery of the Placenta.—To the careful student, it is evident that every stage of labor demands his most earnest attention, but particularly is this true of the third stage, where mismanagement may mar the future comfort or even destroy the life of an individual.

From the earliest times the removal of the placenta has commanded the most serious consideration.

At the present day, there are three recognized methods of conducting the third stage of labor. 1st. That of pure expectancy, resting upon the ancient, therefore honorable, foundation, "Meddlesome midwifery is bad." 2d. The Dublin method and 3d. Crede's method.

The expectant plan consists in permitting the uterus to expel the placenta and secundines, unless their removal is required by hemorrhage or some untoward accident. A superstitious idea pervaded the middle ages, that the retention of the afterbirth portended evil to the parturient, hence its removal by force was urged. This idea was corrected by Ruysch, in Holland, and later by Smellie, Denman and Hunter, in England. When the Dublin method, and later, Crede's, were introduced, it was supposed this vexed question had reached its solution. Within the last five years, however, the question has awakened renewed interest, owing to the reaction on the part of Dohrn, Ahlfield, Kabierske, and others, against the teaching of Crede. While admitting that the delivery of the placenta may be expedited by Crede's method, often without trouble, they base their principal objection upon the increased danger of the retention of the decidua and the production thereby of hemorrhage, putrid processes, and long continued lochia. They claim that the separation of the placenta is due to the accumulation of blood behind it, which gradually completes its separation. Ahlfield formulates two propositions. 1st. The natural powers of normal labor are sufficient for the perfect separation of the afterbirth and the completion of the placental stage, and do so much better and more completely without artificial aid than with it. 2d. The expectant treatment of the third stage is free from danger. Kabierske,* in the Strausburgh clinic, employed the expectant treatment purely. In one hundred cases, the stage was completed within three hours in sixty-nine; in one not until twelve. He cites the fact that Ritgen permitted the placenta to remain

*Montgomery. The Bromide of Ethyl as an Anæsthetic in Labor. *Am. Journ. Obstet.*, vol. xviii, 1885.

†Delivery of the Head in the Second Stage of Labor, with Reference to Prevention of Laceration of the Perineum. *Am. Journ, Obstet.*, 1884, xvii, 580-592.

*Beitrag für Frage über die Behandlung der Nachgeburtsperiode, Centralb. f. Gynäk. 1881, v, 149.

days in the genitalia, so long, indeed, that the odor became unbearable; that Stark, of Jena, in absence of incident, waited for the placenta principally until the third day, while Crantz, Plenk, and Aepli described cases where the placenta was retained from four to fifteen days without disadvantage.

If the retention of the whole placenta is so innocent of danger, it is hard to understand why a portion of the membranes should be so obnoxious.

The complete separation of the membranes is more certain under the expectant plan, but it offers the disadvantage of being more likely to be followed by hemorrhage, relaxation of the uterus and formation of blood clots, which, by decomposition, increase the danger of sepsis. The procedure also permits irregular contraction of the uterus, with incarceration of the placenta, necessitating more frequent introduction of the hand.

Admitting that the plan is safe, is there any reason why the physician should waste an hour—yea, hours, as the zealous advocates of the expectant plan advise—in waiting for nature to complete the delivery of the placenta?

As Baruch* pertinently says, "Why should the accoucheur sit at the bedside, with the hand upon the uterine globe, in uncomfortable expectancy, while the woman, who has just passed through the most fearful ordeal of her life, demands again and again, in plaintive accents, "Doctor am I not yet done, after all I have suffered? What is the matter? Am I in danger? When will I get through? and many other queries indicating an anxious suspense, whose moral effect must be more or less detrimental.

The Dublin method, as introduced by Clark, and followed by Collins and McClintock, consists in following down the uterus with the hand as the fœtus is driven out, securing firm contraction and then applying the binder. The process may be completed by traction upon the cord or placenta.

The foundation of Crede's method is the aphorism, "The uterus itself should expel the afterbirth, and the sooner it does it after the expulsion of the fœtus the better." As Playfair* has said, "The cardinal point to bear in mind is that the placenta should be expelled from the uterus by a vis a tergo, not drawn out by a vis a fronte. An objection to Crede's method is that through it the normal course of the third stage is violently disturbed, and as a result, retention of the membranes occurs more frequently, and, consequently, more frequent disease in childbed.

It should not, however, be performed in such a way as to press or crush the placenta out of the uterus. The method is intended to awaken the uterine contractions. The placenta separates itself from the uterine wall, in the layer in which the cohesion is the least. The relative results of expression and expectancy are shown by the following statistics of Dr. Weis,† at Copenhagen: by which the only advantage shown is that there is less frequent retention of membranes, while, contrary to what would be supposed, secondary hemorrhage is less frequent.

CASES TREATED.	EXPECTANT. Per cent.	EXPRESSION. Per cent.
Post-partum hemorrhage .	5.78	2.3
Manual removal of placenta	1.33	0.64
Retention of membranes	1.78	2.3
Secondary hemorrhage .	0.77	0.32

Of the Dublin and Crede methods, the latter is the more active and, therefore, likely to leave portions of membrane, though the importance of this is questioned. A combination of the two, as Smyly‡ suggests, would be advantageous. Thus, with the hand, follow down the uterus as it expels the child, and make the contraction energetic and permanent. Never remove the hand unless compelled to. During contraction, press the uterine walls together and the whole organ toward the coccyx. When flattening of the uterus shows that the placenta has been expelled from it, drive from the vagina by strong pressure downward. The other hand should receive the pla-

*The Management of the Third Stage of Labor. *Am. Journ. of Obstet.*, 1885, vol. xviii, 359.

*Midwifery, 3d Am. Ed., p. 284.

†Beitrag zur Frage über die Behandlung der Nachgaburtsperiode. Centralb. f. Gynäk, 1881, v, 249.

‡Management of Third Stage of Labor. *Brit. Med. Jour.*, 1885, i, 9-11.

centa at the vulva and hold it, while the uterus recedes. The placenta is then withdrawn until the membranes are put upon the stretch, and so held until the uterus relaxes its grasp upon the membranes.

Antiseptics.—The view of Semmelweis and Hervieux, that puerperal fever is due, as a rule, to the septic inoculation of the wounds induced by the separation of the decidua and the passage of the child through the genital tract, is now, with but few exceptions, accepted. The acceptance of the theory of blood-poisoning in surgery had much to do in bringing this about. It is now mostly accepted that puerperal fever is a species of blood-poisoning resulting from the importation of putrefactive material from without, or its generation in the body of the individual—auto-infection. The source of origin in some cases may be in an old accumulation from chronic peritonitis or salpingitis. Barnes,* divides the poison into endo-sepsis, auto-sepsis, and exo-sepsis. But it is to be questioned whether the second ever occurs.

The disease may be divided into traumatic and putrefactive. The former is simply the febrile reaction arising from the genital lesions, pursues a mild course and terminates favorably; the other is characterized by high temperature, and the symptoms of septicæmia, pyæmia or septico-pyæmia.

It needs only the demonstration of the decrease and almost banishment of the disease under prophylactic measures, to justify the view of the disease being carried to the patient from without.

At Bischof's Clinic, Basle, the mortality, in 1868, was 6.4 per cent. or 1 in 16.

After antisepsis, in 1882, it became 1.6 per cent. or 1 in 63.

At the Maternity, Paris, from 1858 to 1870, the mortality was 9.31 per cent. or 1 in 11. After the introduction of antisepsis by Tarnier it became 2.37 per cent. or 1 in 43, and later, with stricter measures, 1 per cent. or 1 in 100.

In Tarnier's private ward, in 608 deliveries, there was not a single death.

*Antiseptics in Labor. *Amer. Journ. Obstet*, xv, 49.

Accepting the theory of infection as proven, it becomes an important question as to the physician's duty regarding obstetrical cases, when he has been infected by contact with sepsis, either in autopsies, puerperal fever, erysipelas, or cases of septicæmia, how long shall he wait, and what precautions take, before attending cases of obstetrics? This question has been answered variously. Winckel* pleads for two weeks' exclusion; Zweifel† says, the infected hand should not be brought in contact with the genitals of the lying-in-woman for one week. Schroeder‡ recommends two days. E. Martin,§ twenty-four hours. Spiegelberg‖ gave the advice to undertake no obstetrics if one had to do shortly before with wound products, cadavers, or with infectious diseases. Löhlein¶ gives the most reliable advice, however, when he says, "septic germs are not killed by time, but by strict disinfection."

Antisepsis consists of absolute cleanliness upon the part of the physician and nurse, and the withholding from the patient of every possible opportunity for infection. Before examining the patient, the physician, after careful washing of his hands with soap and hot water, should immerse them for several minutes in a 1–2000 solution of mercuric bichloride. He should also see that the hands of the nurse are subjected to the same process.

The external genitals should be carefully washed and the vagina syringed with the same solution. Where labor is tedious the latter should be repeated. Vaginal explorations should be made as infrequently as possible, rather depending upon external examinations for determining the position of the fœtus and the progress of labor. The fingers for examination, and instruments, when used, should be lubricated with borated vaseline ℥j to ℥j. The instruments should be previously immersed in hot

*"Bericte u Studien," Bd. i, u iii, S. 439 u 440.
†"Lehrb. der Operationes Geburtsch," S. 13 u 14.
‡"Lehrb. der Geburtsch," 7 auflag, S. 275.
§"Mon. f. Geb." Bd. xvi, 1860, S. 173.
‖"Lehrb. Geburtsch," 1 aufl. S. 183 u 746.
¶"Der Nutzer einer Aseptischen," Hand. fur den Geburtshelfer, Centralb. f. Gynäk., 1884, viii, 49-52.

water, or preferably in a 10 per cent. solution of carbolic acid.

After completion of the third stage of labor, firm contraction of the uterus having been induced, all lacerations of the external genitalia should be stitched, and when manual or instrumental interference has been necessary, the vagina, or even uterus, washed out with the 1–2000 sublimate solution. Where, however, there was no such interference with the course of labor, nor laceration of the external tissues, it is better to content ourselves with careful cleansing of the external parts with the solution, making sure that no clot or trace of blood is left in the hair covering the genitalia.

The subsequent treatment should be directed to preventing the entrance of septic germs, and securing the rest necessary for repairing the lesions of the genital tract. The binder and pad are applied, to support the uterus and keep it in a state of energetic contraction. The latter is promoted by the administration, three times daily, of quinine, ergot, and tinct. digitalis, for the first week. An aperient the second day aids nature in the elimination of any poison that may have found entrance. Where no laceration has occurred, drainage should be promoted by having the patient sit up on the commode to pass water and evacuate the bowels.

Many authorities have recommended the daily, yea several times daily, employment of carbolized or sublimated vaginal injections, but such treatment interferes with the proper rest of the parts, tears afresh the wounds, and endangers the introduction of septic material.

Experience has shown that vaginal, and much more, intra-uterine injections, in the absence of septic symptoms, are not only valueless, but positively injurious, and has led such men as Baker, Thomas, and others, to revise their earlier teaching. We need but to compare the results in the following table, prepared by Baruch,* to convince ourselves of the truth of this statement.

HOSPITALS IN WHICH INJECTIONS ARE PRACTICED.	MORTALITY per cent.
Charite, (Hartmann)	2.5
Charite, (Gusserow), av. 1870-81, inclusive	1.5
Charite, (Gusserow) Summerbrodt, 1882	1.6
Maternity at Parma	3.42
Glasgow Maternity (new building)	1.56

HOSPITALS IN WHICH INJECTIONS ARE NOT PRACTICED.	MORTALITY per cent.
Pavillon, Tarnier, Paris, 1880 to June, 1883,	0.
Prague Maternity, 1880, (Breisky & Weber),	0.46
Prague Maternity, 1880, (Breisky & Weber),	0.56
Breisky, (Fischel), 1881	0.21
Briesky's Ward alone, 1882	0.
Copenhagen Maternity, 1880	0.26
Copenhagen Maternity, 1881	0.5
Prague, 1883, 1100 cases	0.
N. Y. Maternity, 3d series, Dr. Garrigues	0.

The lochial discharge from the vulva is the principal source for the entrance of septic germs. Garrigues* suggested keeping the vulva covered with a pad of lint saturated with a 1–2000 sublimate solution and this with oiled silk and cotton. Where there is a free bloody discharge, however, this obstructs its exit, and sometimes causes the uterus and vagina to be distended with a clot. Careful cleansing of the external genitalia, every six or eight hours, with the sublimate solution, and the application of clean napkins meanwhile, seems to answer well. The putrefaction of the lochia takes place where it comes in contact with the air, and the poison is transmitted to the parts above. The frequent washing prevents such change. Nurses and midwives should be impressed that it is not only the discharges of puerperal patients that are poisonous, but their hands may be the media for conveying infection, after handling any decomposing materials, as meats, in the kitchen, dressing cancerous sores, touching menstrual blood, etc.

Of the antiseptics, greater prominence has been given, in the above remarks, to the value of corrosive sublimate. From its great power as a germicide, one would naturally expect great benefit from this agent, in an infectious disease. Carbolic acid cannot be used in sufficient strength

*Prevention of Puerperal Fever. A Study of Antiseptic Practice in the Maternity Hospitals of Paris, Prague, Berlin, Parma, Glasgow, Copenhagen and New York. *N. Y. Med. Journ* 1884, xxxix, 322-327.

*Prevention of Puerperal Infection. *N. Y. Med. Journ.*, 1884, xxxix, 243.

to destroy germ life, without burning the tissues.

That the sublimate solution has proven in practice the most reliable agent, the experience of Williams,* in the London-Lying-in Hospital, goes far toward demonstrating. During four years, in 1174 deliveries, seven deaths occurred, a little more than 0.5 per cent. In the first twelve to eighteen months carbolic acid was used; during a second similar period permanganate of potash, and since May, 1884, corrosive sublimate. In the first two periods there was considerable illness, though the mortality was low. With the use of corrosive sublimate there were no deaths and an almost entire absence of mobility.

In conclusion, we would formulate the following creed:—

1. The hydrostatic dilating force of the first stage should be preserved until the genital tract is completely dilated, and imitated when lost.

2. The vital forces of the patient should be economized by the abatement of pain in the first stage, by opium, in the second, by the bromide of ethyl.

3. The uterus should be encouraged to complete the third stage as soon as consonant with the entire discharge of the placenta and secundines. This should occur by expression, not traction upon the cord.

4. The most strenuous precautions should be taken, during labor and subsequent convalescence, to prevent the development of putrefaction.

Pyridin in Asthma.—In Professor Germain Sée's clinic in Paris, Rosenblück (*St. Petersburg Med. Wochenschrift*) has tried the action of pyridin in various forms of asthma. The nervous and emphysematous forms were rapidly relieved; nausea and giddiness being noticed only once. The presence of bronchial catarrh is no contraindication to the treatment, which was carried out by allowing four to five grams of the liquid to evaporate from a flat dish in a small room, the patients being exposed to the vapour for one hour and a half three times a day.—*Brit. Med. Jl,*

*Discussion. *Edinb. Med. Journ.*, 1884-5, xxx, 781.

Clinical Lectures.

PULMONARY PHTHISIS WITH EXCESSIVE DYSPNŒA THE RESULT OF EMPHYSEMA.

A CLINICAL LECTURE, DELIVERED AT THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA, BY WILLIAM PEPPER, M.D., LL.D.,

Provost of, and Professor of Theory and Practice of Medicine and of Clinical Medicine in the University of Pennsylvania.

Specially reported by William H. Morrison, M.D., for the Maryland Medical Journal.

Gentlemen. We learn from this patient that he is married, that he has led a regular life and has followed a hard and exposing occupation, that of a butcher. He has indulged in no dissipations. His family history is not good, his mother and one of her sisters dying of phthisis. His mother died at the early age of thirty. This patient is twenty-seven years of age, His general health has been fair. About six years ago he had a severe attack of pleurisy which kept him in bed three weeks. He then continued well until two or three years ago when he noticed that he became short of breath on exertion. This continued, but his health seemed about as good as usual until the early part of this year, when he noticed that he began to run down in flesh, to grow weak and that the shortness of breath grew worse. At the same time, he began to raise phlegm. He says that his cough is very slight. You may be told by a patient that he has no cough, and yet if you pursue your questioning, you will learn that there is, as in this case, an expectoration which the patient thinks is only from the fauces. He says that there is no cough but merely a little clearing of the throat in the morning. If you are not careful you will often be in danger of being thrown off the track by such statements by the patient. It is evident that this patient has a heavy purulent expectoration in the morning, amounting to about half an ounce and that it is brought up without any straining cough. We are never to be misled by the ab-

sence of hard spells of coughing. Sometimes, the amount of cough is very great, and the expectoration slight. Sometimes the patient will deny that he has a cough, and yet will bring up considerable matter from the lungs. There may be extensive physical changes in the lung where the patient tells you that he has neither cough nor expectoration.

This patient has had no hemorrhages from the lungs. The febrile action is slight and night sweats are wanting. There is no evidence of serious disturbances of the digestive function. There is a little dyspepsia, but no diarrhœa. The hands are cold and the nails a little bluish. The ends of the fingers are perhaps a little enlarged. There is a little tendency for the fingers to be bulbous as though there had been long standing venous congestion.

So far as we have gone in the history of the case, it is impossible to form a diagnosis. The history, the purulent expectoration and the rapid loss of flesh, would point in the direction of pulmonary phthisis, but uncomplicated pulmonary phthisis would not account for the shortness of breath which was present for two years before the expectoration began. In young subjects, where there has not been repeated spells of bronchitis bringing on emphysema, a history of dyspnœa lasting for a year or two before the appearance of cough and expectoration is unusual. The most ordinary explanation of this would be the existence of cardiac disease. Our patient has not suffered from rheumatism. He has not spoken of palpitation of the heart and complains of no pain in the præcordia. Again, it is unusual for cardiac disease to become complicated with organic pulmonary disease. I do not say that they are totally antagonistic and mutually exclusive, but their combination is very rare. You rarely find phthisis developing in a case of organic heart disease and you rarely find organic heart disease developing in the course of phthisis. I am therefore not disposed to think that we shall find that the dysponœa was dependent upon heart disease. These considerations present themselves in such a case and it is well to pause before beginning the physical examination, and run over in our minds what probable pathological combinations we may expect to find. While on the one hand it is a great danger to settle your mind upon a lesion and then set to work to find that lesion by physical exploration, for unless your mind is well trained, you will find something just because you look for it and not because it exists; yet on the other hand it is a great assistance if you run over in your mind before hand, the leading conditions which you may expect to find and then begin without any prejudice in favor of one or another and make a thorough examination to see if such conditions exist.

As I have said, in phthisis the amount of cough and the amount of expectoration very often bear either no relation or an inverse relation to each other. In some cases the patient coughs a great deal and expectorates a great deal, the cough and expectoration bearing a direct ratio to each other, and the lungs undergo still further changes, the breath becomes shorter and shorter, the difficulty in breathing bearing a direct ratio to the condition of the lung. I would, however, ask you to observe that body wastes as the lungs waste and the need for oxygen decreases, so that sometimes from the beginning to the end there is no conscious dyspnœa. There may be shortness of breath on exertion, but the patient does not complain, for the demand for air has been cut down as the lungs have become degenerated. While this is often the case, we frequently meet with great departures. You sometimes meet with severe cough where there is a trifling amount of disease and very little expectoration. In such cases there is extreme irritability of the bronchial mucous membrane. Just the opposite condition, copious expectoration with slight cough, may be met with.

The shortness of breath varies. There may be marked dyspnœa when the physical examination shows very triffling lesions in the lungs.

Let us now examine the heart. I find that its impulse is extended and its action rapid. There is, however, on auscultation,no evidence of valvular disease.

When as in this case, we hear the dyspnœa exist out of proportion to the amount of cough and expectoration, our first suspicion would be the co-existence of cardiac disease, but in this case we are compelled to exclude this as the heart is healthy.

What other explanation could we have of excessive dyspnœa with moderate cough and slight expectoration? The next thing that occurs to you would be that the patient had a latent pleurisy, compressing one or the other lung and adding greatly to the dyspnœa while it would not increase the cough or expectoration. I shall then search for pleural effusion or extreme pleural thickening. A rapid examination of the chest reveals good resonance at the base of the chest posteriorly, and this excludes pleural effusion and any amount of pleural thickening, sufficient to explain the interference with breathing.

The third condition that one would think of in studying such a case would be that the patient had chronic bronchitis and emphysema and that the emphysema was the cause of the dyspnœa and that phthisis had been superadded to the bronchitis and dyspnœa. While it is true that chronic bronchitis will sometimes cause rapid breaking down of health and such rapid loss of flesh as we see here, yet, in such cases, there would be a great deal more cough and much more expectoration than has been present in this case. Hence we could not explain the rapid failure of the man's health on the supposition that he had chronic bronchitis and emphysema. The man may have bronchitis and emphysema accounting for the shortness of breath and then a disease of a more serious character developed, causing the rapid failure of general health. Therefore phthisis associated with emphysema is another explanation of such disparity as is here seen between the dyspnœa and the cough and expectoration.

Let us then examine for the symptoms of emphysema. The typical chest of emphysema is the globular or barrel shape. This man's chest approaches the typical chest of phthisis. It is a long flat shallow thorax, with over-hanging humeri and projecting scapulæ. The alar or winged chest or phthisical thorax is fairly representated by the chest before us. It is, however, not true that in all cases of emphysema the chest undergoes this globular distention. There is an atrophic emphysema as well as a hypertrophic emphysema. In the typical form, the lung becomes distended. In other cases, the lung may contract and yet the structure may be highly emphysematous and the general symptoms may be those of emphysema. This is not rarely the case where there is serious organic disease associated with the emphysema. The fact that this chest is not emphysematous in form, is not sufficient to exclude the presence of this affection.

The physical signs of emphysema are weak inspiration, prolonged expiration and exaggerated percussion resonance. Over the front ot the left chest, I find weak respiratory murmur, but the expiration is not much prolonged. When the patient takes a strong inspiration after coughing, gurgling râles of a somewhat moist character are heard down to the third rib. Below that point, they are of a fine dry crackling character. On the right side, the respiratory murmur is very feeble and the expiratory murmur is also feeble and a little prolonged, and there are more numerous râles. They are moist from top to bottom, but with them there are a few coarse sonorous râles. Along the posterior surface of the left chest, the respiration is weak up to the spine of the scapula. Above this point the breathing is the best I have yet heard. At the upper part of the right chest posteriorly, the breathing is blowing on inspiration. Moist râles are heard in this situation. Over the lower portion of the right chest there is weak breathing and a few râles.

What do we conclude from the physical signs thus far elicited, as bearing upon the important question whether the patient has atrophic emphysema with bronchitis and with or without phthisis? You will observe that the physical signs are bad at the top of both lungs and that they are even worse in front than behind, with the ex-

ception of the weak breathing which is quite marked over the posterior surface of both lower lobes. The fact that both lungs are involved in the disease is not bad in itself, indeed I was going to say that it was a good element in prognosis, because it rather favors the idea that a man who is able to be about with such evidences of extensive disease, the symptoms cannot be entirely due to tuberculosis. I am always glad to find the certain symmetry in the lesions in such cases as this for bronchitis and emphysema are essentially bilateral diseases, while tuberculosis, especially a chronic phthisis is essentially unilateral at first. If you find a cavity in one lung and gurgling râles through the lower lobe of the other side, you know that you have a case of chronic tubercular disease with secondary development of tubercles in the other lung. If you find the râles equally distributed through both lungs, although the condition of the patient may appear to be unfavorable, yet the lesion is probably of an inflammatory nature. Of course, these remarks to do not apply to cases in the last stages of phthisis when both lungs are riddled with tubercles from top to bottom. It is clear that our patient is not in that condition. If the evidences of disease were confined to the posterior part of the lower lobes, it would be even more favorable, but they are most marked in the upper lobes where the lesions of phthisis are most commonly found. The anatomical distribution is therefore unfavorable. We have already proven the existence of emphysema in this case. The increased percussion resonance with the weak respiratory murmur heard over the lower lobes behind, establishes the existence of emphysema. If this man had phthisis as he has at the apex of the lungs, and if the lower lobes were healthy, we should expect to have exaggerated respiratory murmur. Instead of this, the respiratory murmur is very weak. The only thing which causes exaggerated resonance with weak respiratory murmur is vesicular emphysema.

Next comes the question whether the man has chronic bronchitis or phthisis with this. I have already pointed out, that the fact that the physical signs are especially marked over the upper lobes in front is unfavorable. Important information is to be derived from noting whether at any particular part of the chest, the breathing in dicates either consol idation or excavation, whether it becomes tubular or still more cavernous. In the case of one simple emphysema with chronic bronchitis, these should not be found. If there is infiltration and consolidation or still more if there is softening and vomicæ, the respiration will indicate these changes. We have already found over the right scapula, blowing breathing on the inspiration and expiration. In some cases of chronic bronchitis, the bronchial tubes may undergo dilatation. The softening of the walls with repeated shocks of hard coughing, straining the lung tissue, may induce dilatation. There may be at the root of the lung a dilated bronchus or a tubercular cavity. I attach less importance to such changes in the respiratory murmur in this situation than I would if they were heard in the supra-clavicular space.

We now turn to percussion as an important aid in settling this question in differential diagnosis. In chronic bronchitis with emphysema, we should find increased percussion resonance everywhere. If, however, we have dullness on percussion or tympanitic resonance, the evidence of destructive disease of the lung would be positive. Under the left clavicle the resonance is impaired. Under the right clavicle, this impairment is more marked. There is at this point, a small high-pitched tympany which suggests either consolidation around a primary bronchus, or more probably a small deep seated excavation. In the right supra-clavicular space the resonance is impaired, in the remainder of the chest the respiratory murmur is good. Over above the right scapula, there is whispering pectoriloquy. There is also decided increase in the vocal resonance and spoken voice. This is not so marked in front. In this case, we also unquestionably have the lesions of emphysema and of chronic bronchitis. The emphysema is, however, far in excess of the history of bronchitis. There has been

in this case a tendency to giving away of the septa between the air cells as a result of inherited anatomical weakness, so that the tissue of the lungs has undergone emphysematous degeneration with very little bronchitis. There are also the lesions of established phthisis at the apex of both lungs, which is somewhat more advanced on the right side. On the right side, there is a small deep seated cavity surrounded by indurated tissue.

There is one final condition to which, on account of its great importance, I must allude in closing; that is where there is extreme dyspnœa out of proportion, to the cough and to the amount of expectoration and where there is no heart disease and no pleural effusion, where on examination you find neither the history nor the evidences of bronchitis and where the general symptoms are in excess of the local symptoms, the lung is sometimes being stuffed with miliary tubercles which actually impede the entrance of air into the bronchial tubes, and dyspnœa results. In acute, diffused tuberculosis, you may meet with symptoms which might cause you to mistake this for simple emphysema. The great weakness of the respiratory murmur, the prolonged expiration and the absence of any marked evidences of consolidation or excavation might lead to this mistake. In such a case, the general symptoms are of course very serious. There is marked fever, the dyspnœa is extreme and out of proportion to the physical changes that can be demonstrated and the history of the case would not justify the view of emphysema and chronic bronchitis. There might also be some centre of cheesy degeneration which would explain the eruption of tubercle.

The ultimate analysis of a case of this kind is attended with a high degree of interest. Any one by percussing beneath the clavicles could make the diagnosis of phthisis in a few minutes, but such a method as I have pursued before you to-day is profitable and instructive as a matter of mental training. The rapidity with which the health has failed and the back-ground of the case is unfavorable. The absence of hemorrhage, the absence of diarrhœa and the absence of marked fever and night sweats are in his favor.

This man should be kept at rest. The slightest exertion is injurious. He should have frictions with the innunction of oil. The hygiene and diet should be carefully regulated. In addition, he should receive some stimulant expectorant as carbonate of ammonia combined with some nutrient- If he could in addition take cod-liver oil in some form either peptonized or in the form of an emulsion, all the indications would be met. There is no cough, excessive expectoration, fever, night sweats, or other symptoms requiring treatment. What he needs is rest and promotion of the circulation and nutrition. This will be best secured by the method of treatment suggested.

Clinical Reports.

A FATAL CASE OF OBSTRUCTION OF THE RECTUM.

BY T. C. PEEBLES, M.D., OF LUTHERVILE, BALTIMORE CO., MD.

March 18th. I was called to see F. G., a maiden lady about 50 years of age. She complained of feeling bilious, had not been well all winter and has had a tendency to constipation for several months, but from her dislike to taking medicines had neglected seeking advice or doing anything more than taking a purgative pill occasionally. It is now a week since her bowels have been moved, yet she does not feel any inconvenience or distention of the abdomen. Her tongue is a little furred, she has no fever, pulse 65, has lost her appetite and has a slight headache.

I prescribed two grains of calomel and two of ext. colo. co. to be repeated at bedtime.

On the following day I found that the medicine had not acted on the bowels, the patient had taken to her bed feeling very despondent about herself. I could find no pain over any part of the abdomen. Pulse under 70, temperature normal. I ordered stimulants and beef tea, also copious injections of warm soap

suds to be followed, if unsuccessful, by turpentine injection.

March 22d. Bowels have not been relieved by injections. Pulse 76, temperature 99°. There is a little distention of bowels, with some dullness in the right inguinal region over the sigmoid flexure of colon. No tympanitis, and no tenderness under pressure.

Dr. J. Pennington, of Baltimore, saw the case with me in the afternoon and he advised repeating purgative medicines by the mouth. He did not seem to take a very serious view of the case, indeed, I may say up to this time the most marked feature was the patient's utter depression. She said "she was going to die and that nothing could save her." In talking the case over with Dr. Pennington, I told him that my experience taught me not to place much reliance on a low temperature in abdominal troubles, as I had seen several deaths occur when the thermometer did not rise above 101°. (The late Dr. Riggin Buckler confirmed my views, in a conversation we had on this subject.) Up to March 24th, the bowels had not been moved. Dr. Pennington met me in consultation in the afternoon. The patient has been able to take nourishment, but to-day vomited twice. Pulse 65 and very feeble, respiration 14, temperature 100°, which is the highest point reached.

The previous injections had been given by a female friend. I now used a Davidson syringe, with warm soapsuds, myself and found that the water returned from the rectum unsoiled. I then tried to pass a gum-elastic tube of a stomach-pump into the rectum, but found it was arrested at a point 5½ inches above the anus. I then substituted a No. 12 male catheter, but with the same results. Dr. Pennington also tried, but there was a firm blocking up of the bowel. As the patient was unconscious and almost moribund, besides there was no likelihood of our being allowed to make a post-mortem examination, I proposed to Dr. Pennington, as his hand was smaller than mine, that he should try to pass it into the rectum and examine the obstruction, but the patient died before he could succeed. I regret in this case that I did not give the injection myself on my first or second visit, but my patient being an old maid, would not submit.

From the first day I saw the case to its termination, I do not think there was a moment when the patient had sufficient vitality to have sustained any surgical operation and from the general aspect and complexion I suspected malignant disease.

Correspondence.

DR. C. D. MEIGS AND THE FORCEPS—A REPLY TO DR. HOWARD.

BALTIMORE, Dec. 26, 1885.

Editor Maryland Medical Journal.

DEAR SIR: — Dr. Howard's reply in your issue of the 19th of December convinces me that *my* memory, and not *his*, was at fault in regard to his authority for the remarks he made in connection with Dr. Meig's confession of his neglect in not having his forceps at hand, and the fatal results to the child.

I am obliged to him for the correction. But I hope a failure of memory at 63 is not unpardonable, and that my zeal in defending the reputation of our venerable teacher will, in some measure, both explain and atone for it.

Whether so trifling an issue as a question of memory justifies so formal a reply, with its trite Latin motto, seldom employed, except in grave, polemical discussion—and its caption, "Critic Corrected"—is a question of taste, and, therefore, I shall not discuss it, but I confess, the extragant importance which it gives to the trifling issue between us, made me smile, and reminded me of—

> "The ocean into tempest tossed
> To waft a feather, or to drown a fly."

I am not aware, before Dr. Howard mentioned it, that the reputation of the Jefferson was at all in dispute. Thank God! she needs no defenders. Her brilliant record is her best and sufficient defence.

Upon what evidence afforded by my correspondence in this matter, the Doctor assumes from his recollection of a case that I had forgot, that he "better understands the teachings of our common

master," is not very clear, as we both agreed upon the importance which Dr. Meigs attached to being provided with the forceps in such cases, and our only difference was as to whether Meigs had ever violated his own rule. If the Doctor's claim of superiority has reference to his better understanding of his own specialty, I concede it at once, but would have preferred to have done it voluntarily than on his demand.

But whatever may be my ability to understand and remember the teachings of my venerable preceptor in this respect, I hope I shall never forget his love of truth and candor, and be always willing like him to acknowledge an error without feeling any loss of self-respect or temper.

Yours Respectfully,
JOHN R. QUINAN, M. D.

MITRAL STENOSIS—Constriction of the mitral orifice is, on many grounds, the most interesting of the valvular affections of the heart. It is common and at the same time dangerous, standing, in point of danger, next to aortic incompetence; being, indeed, the more serious of the two in early life, so that it has a very practical interest. Its clinical history, again, presents peculiarities, some of which have long been recognized, while others have not yet received adequate notice. The special claim of this condition, however, upon out attention, arises, as Dr. W. H. Broadbent, of London, points out in an able article in the January number of *The American Journal of the Medical Sciences*, from the fact that it presents greater difficulties in diagnosis than any other disease of the valves. It was the last of the valvular lesions to be associated with distinctive physical signs, and it is still not unfrequently entirely overlooked by physicians, while more commonly it is diagnosed as mitral incompetence, which is a far less serious affection. The physical signs are, in fact, extremely varied, and the attempt to elucidate their significance, and especially to attach diagnostic and prognostic meaning to some of the combinations of modified sounds and murmurs, is the chief object of this paper.

ON RECENT GYNECOLOGY. — Recent gynecology, whether major or minor, owes much to the spirit of the times; but major gynecology has had powerful, prospering, favorable gales from recent discoveries. Dr. Matthews Duncan, in an article on "Recent Gynecology" in the January number of *The American Journal of the Medical Sciences*, says that we may safely affirm that, without the anæsthetics of America, and the antiseptics of Lister, recent gynecological surgery could not have attained its great position. To foresee the danger unattend by the agony makes a ready, willing patient. To foresee the great source of danger, and to provide against it, emboldon the surgeon.

Among the more adventurous spirits of gynecological surgery there is a risk of obliteration of the distinction between feasibility and advisability. They have proved that any operation is feasible, and now they have more difficult tasks; as, for instance, to show what operations are advisable, and how they may best be done, and when they may best be done. At what period in a case should ovariotomy be undertaken? Are there any cases besides those of uterine hemorrhage immediately imperilling life in which the operation of Battey should be done? What are the cases in which hysterectomy should be practiced for fibroids? What part should age take in favoring or discouraging operation in cases of hemorrhage? Is hysterectomy ever advisable in cases of cancer of the portio vaginalis, or in cases of cancer of the cervix? What are the limits of the use of hysterectomy in cases of cancer of the body? In what cases of extrauterine fœtation is laparotomy to be resorted to, and when? Major gynecology is too young to have laurels; its laudable zeal scarcely requires fostering. Minor gynecology requires pruning and direction, and even preliminary education, rather than fostering.

The total expenses of conducting twenty-one hospitals in New York City last year, were $601,801,44. The number of patient treated was 11,969, of whom 9,332 were free patients.

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BALTIMORE, JANUARY 2, 1886.

Editorial.

OÖPHORRAPHY AND JEJUNOSTOMY.—The wide-awake and progressive character of the scientific growth of the present age is shown in more ways than one, but a most distinguishing feature is exhibited in the facility with which new operative procedures are devised for the relief of various pathological conditions and new names are coined to designate the operative methods employed. Oöphorraphy and Jejunostomy are the most recent illustrations of this tendency to devise new operative methods and to coin new names for the same. Oöphorraphy is the term employed to designate a new method of treatment for prolapsed ovaries. The word and the operation owe their existence to the ingenuity of Dr. Imlach, of England. At a recent meeting of the British Gynecological Society, (*British Medical Journal*, December 5th) held November 11th, 1885, Dr. Imlach read a paper, having the title of oöphorraphy, in which he undertook to show that the satisfactory treatment of prolapsed ovaries was an acknowledged difficulty. Pelvic pain, irregular menstruation, inability to walk without distress, painful defæcation and reflex vomiting are common results of prolapsed ovaries. Dr. Imlach had known removal of the ovaries to be advised even by those surgeons who vehemently denounced the operation for the removal of the uterine appendages for inflammatory disease of the tubes and ovaries. In painful prolapse, there was often adhesion of the ovaries in Douglas's space, and some degree of ovaritis. In many cases, he considered this pain chiefly due to the tension and distortion of the parts. When the Fallopian tubes were diseased, he considered no other treatment than removal of the appendages worthy of regard. But, he argues, pathology, like surgery, must be sober, and should distinguish the varieties of inflammation. It was no deprivation to remove the ovaries when there was abscess, when they were riddled with cysts or pultaceous; but when there was any healthy structure left, and the tubes were uneffected, Dr. Imlach considered it somewhat ruthless to take away all chance of child-bearing. Though chronic ovaritis was considered no more curable than chronic Bright's disease of the kidney, ovulation continued and pregnancy might occur, so long as there was only partial thickening of the parenchyma and the Graafian follicles were not wholly destroyed.

In young women, when symptoms were so inveterate as to require surgical treatment, Dr. Imlach now performed oöphorraphy in place of oöphorectomy. In the virgin, the ovaries were suspended by the peritoneal folds of the broad ligament stretching from the pelvic brim to the infundibula of the Fallopian tubes, but after childbirth these folds relaxed and the ovaries were suspended by the utero-ovarian ligaments; when this relaxation of the infundibulo-pelvic ligaments was exaggerated, which might happen without previous childbirth, the ovaries being vertically downwards, become congested and were painfully prolapsed. For this condition Dr. Imlach has adopted the method of suturing the hilus of the ovaries to the relaxed infundibulo-pelvic ligaments near the brim. In this manner the virginal position of the ovaries was restored. Details of fourteen cases were given in which this operation was performed with recovery and entire relief of all the painful symptoms. Oöphorraphy is in this manner

elevated into prominence as a legitimate procedure for the treatment of prolapsed ovaries.

Jejunostomy. Simultaneously with the announcement of the new operation of oöphorraphy we are enabled to introduce to the notice of our readers the operation of Jejunostomy which is entitled to notice as a surgical novelty and which has quite recently been performed by Dr. C. H. Golding-Bird, of London. The announcement of Dr. Golding-Bird's operation was made before the Clinical Society of London, at its meeting held November 27, (*British Medical Journal*, December 5th, 1885). The patient upon whom the operation was performed was a man, aged 46, who had had symptoms of pyloric obstruction for ten months. A tumor occupied the seat of the pylorus, and extreme emaciation had taken place through an inability to retain food. On October 25, 1885, Dr. Golding-Bird cut down on the pylorus with a view to performing pylorectomy; but finding the tumor adherent to the liver, he determined to go no further in the radical operation, but to convert it into a palliative one by opening the jejunum. The jejunum was accordingly seized two inches from the duodenum; it was held on a pair of tongue-forceps, whilst the wound in the parietes was united; to the lower or right end of this wound, the jejunum was now stitched by interrupted suture. The patient suffered in no way as a result of the operation. He was fed partly by the rectum and partly by the mouth, until the third day, when the bowel was opened, and food administered solely through the fistula. It was observed that, as long as the meal amounted to a pint or nearly so, the patient had indigestion, but that this ceased when the meal did not exceed ten ounces. Everything went on well until the ninth day when through an error in feeding him, some food passed into the peritoneum and he died in twelve hours. The post-mortem showed that pylorectomy would have resulted fatally, and also that adhesion had taken place between the jejunum and parietes at every point except the one made by the probe. But for this accident the result would have been highly favorable in prolonging the patient's life. Mr. Golding-Bird considers jejunostomy the the best palliative operation for pyloric cancer, since it invites less risk and requires less interference in its performance with other viscera. He pointed out the fact that by duodenal digestion full nourishment could be received with less chance of regurgitation of food than after gastrostomy.

Sugar as a Dressing for Wounds.—Attention has been called to the value of sugar as a dressing for wounds by several authorities. From the testimony offered it appears that this valuable article of diet has more than one influence in promoting the comfort of mankind. In the *Centralblatt f. Chiry.*, No. 48, 1885, Dr. F. Fischer gives his experience with the use of sugar as a dressing for wounds in the Surgical Clinic at Strassburg. Since April, 1883, corrosive sublimate has been used for the disinfection of wounds, and since May of the same year pulverized sugar has been employed for the same purpose. The sublimate solution 1–1000 was used for irrigation of the operative field, whilst for disinfection of hands and drains, sponges and catgut, as well as for a spray for disinfection of the air before laparotomies, a 5 per cent. carbolic acid solution was used. The antiseptic power of sublimate has proved especially great as a protective against erysipelas. The toxic symptoms of the drug, with the exception of a case of nephritis hemorrhagica and two cases of bloody diarrhœa, consisted of frequent cases of stomatitis of various grades.

Sugar has a weak but decided antiseptic qualities, and prevents, to a certain extent, the decomposition of organic liquids. At first it was used mixed with equal parts of naphthaline, or with iodoform in the proportion of 10–1, but since the winter of 1883–4 it has been generally used undiluted, being mixed with iodoform only in the treatment of tuberculous affections. Wounds with loss of substance or cavities are sprinkled or filled with sugar, whilst sutured wounds are covered with sugar bags.

The effect of sugar upon flabby and foul ulcerated surfaces was very marked. They rapidly cleaned up and became healthy. On the contrary the sugar dressing proved itself unsuitable for wounds with free secretion. Many dressings are allowed to remain from eight to fourteen days undisturbed. A small amount of secretion forms with the sugar a dry crust, whilst a larger amount dissolves the sugar, which then requires a new sack to be applied.

The results of this sublimate-sugar wound treatment were excellent and show that after thorough disinfection of the wound with sublimate solutions, and proper drainage, the sugar serves perfectly to protect the wound from infection from without, and to preserve the secretions from decomposition. A great advantage claimed for the method is that no poisonous substance is brought in contact with the wound after it has been once disinfected. Of 202 cases treated with sugar five died, one from erysipelas, one from nephritis hemorrhagica, one from sepsis in existence at the time of operation and two from phthisis pulmonalis. Of 37 major amputations 31 healed by primary intention and the others in a short time.

The method here related certainly commends itself for its simplicity and for the cheapness and ease with which it can be used. Sugar is an article of ready access and it is as harmless as it is convenient. It seems to us to deserve a fair trial at the hands of our surgeons.

Miscellany.

The Production of the so-called "Rose Cold" by Means of an Artificial Rose.—Dr. John N. Mackenzie, of Baltimore, relates, in the January number of *The American Journal of the Medical Sciences*, a unique case, which, among its many other interesting features, forcibly illustrates the *rôle* of purely psychical impressions in awakening the paroxysms of the disease familiarly known as "rose cold."

While we cannot fail to recognize, as Dr. Meckenzie points out, the important relation of olfaction to the imaginative faculty, and the frequency with which it serves as the connecting link between associated ideas, and while the above cases illustrates the psychical element in the *excitation of the paroxysm*, it must not be considered that the affection itself is a disease of the imagination, a purely psychological phenomenon dependent solely upon a deranged mental impressibility. For both our present knowledge of the affection and the history of the case itself, militate against and destroy such a supposition. Indeed we should distinguish carefully between a disease having a definite clinical history and subject to recognized pathological law, and a mere perversion of the perceptitive faculty, although the latter may occasionally act as an exciting influence in the production of the paroxyism of the former. The chief lesson to be derived from the study of this particular case (*i. e.*, so far as the psychical element is concerned) is that it opens our eyes to the fact that the association of ideas sometimes plays a more important *rôle* in awakening the paroxysms of vasomotor coryza than the alleged vital property of the pollen granule.

Chicken-pox and Small-pox. — M. d'Heilly, of Paris, during an epidemic in his wards of chicken-pox, made several inoculations, which succeeded three times in ten. Trousseau attempted, but was always unsuccessful; Steiner succeeded in eighty per cent. After successful inoculations, chicken-pox is not preceded by prodromata. The period of incubation is from three to seventeen days, an average of from fourteen to seventeen. Chicken-pox always resulted, and never small-pox. One of the children had been previously attacked by small-pox; the subsequent attack of chicken-pox ran its usual course. In children previously vaccinated and then inoculated with small-pox, the vaccination-pustule dried on the eighth day; chicken-pox appeared on the twelfth, and followed its ordinary evolutions. In one case, a small-pox eruption appeared two days after the chicken-pox eruption,

and went on through all the stages. M. d'Heilly considers that these facts demonstrate that chicken-pox and small-pox are two distinct diseases. The period of incubation can be co-existent or follow closely one after the other. Chicken-pox vaccination did not leave any marks, and the eruption was not near the area of vaccination. M. d'Heilly vaccinated from chicken-pox vesicles on the second day. M. Dumontpallier observed that M. d'Heilly's experiments were not conclusive, because the children vaccinated for small-pox remained in the ward among the children suffering from this disease. The experiments of the same kind he had made with Trousseau all failed, the children were removed from contact with chicken-pox patients.—*Brit. Med. Journ.*

Affections of the Eye Accompanying Mumps.—The implication, either concomitantly or by a process of metastasis, of other and distant organs during an attack of mumps, is a well-known peculiarity of that disease. The method of this transference is one of the many questions pertaining to that obscure disease that yet remain to be solved by the general pathologist. The testicle in man, and the mammary gland in women, have been recognized from the earliest history of medicine as the object of this metastasis of disease from the parotid glands; and within late years the ear has been discovered to stand in a similar unfortunate relation. That another important organ of sense was in danger from this usually mild and innocent affection is now pointed out by Dr. Swan M. Burnett in the January number of *The American Journal of the Medical Sciences.*

From a study of the cases reported up to the present time, he finds that the principal parts of the eye to suffer from a metastasis of the mumps to that organ are the lid, conjunctiva, and optic nerve, and also in his case the third pair of nerves. The disease may be unilateral and of varying degrees of intensity. The prognosis of the affection seems to be, in the main, good. This, however, suggests the possibility that some of those atrophies of the optic nerve, especially when unilateral, which are accidentally discovered, and the origin of which cannot be traced to any of the hitherto recognized causes, may be due to a metastasis of mumps in childhood.

The Influence of Cascara Sagrada on the Digestive Secretions.—Cascara sagrada has been experimentally studied by Dr. M. Tschelzow (*Centralb. für die Gasammte Therapie*, August, 1885), who comes to the following conclusions:

First. Cascara sagrada is useless when a rapidly-acting cathartic is desired.

Second. It only acts as a cathartic when introduced into the stomach. When injected subcutaneously or directly into the blood-vessels it produces no evacuation of the bowels.

Third. Cascara sagrada does not increase the secretion of saliva.

Fourth. It produces an increase in the secretion of gastric juice, which continues even during digestion.

Fifth. It increases both the pancreatic and biliary secretions.

These results were obtained when the drug was directly introduced into the stomach. When injected into the circulation, the animals rapidly passed into a condition of collapse, which soon proved fatal, or they recovered but very slowly; while the blood-pressure was rapidly reduced, even after previous section of the pneumogastrics.—*Ther. Gaz.*

Longevity of German Professors.—It is said that there are at present at the various German universities no fewer than 157 professors between the ages of seventy and ninety. Of these 122 deliver their lectures as usual. The oldest is the veteran Von Ranke, the historian, who is now in his ninetieth year, but is not considered fully equal in vigor, memory, and other faculties to Professor Elvenich, who is thirty-nine days his junior.

Bite of Rabid Animal.—For the effectual cauterization of the bite inflicted by a rabid animal, a few drops of strong mineral acid are worth all the lunar caustic in all the chemists' shops in London. Means nearer to hand, and as effectual when thoroughly used, are found in the actual cautery—which can be extemporized out of an ordinary knitting pin or the points of a pair of scissors heated to bright redness in the fire. Another means, even more readily available in some cases, is found in gunpowder, which can be placed on the wound and fired by an ordinary match. This is a plan which has been adopted in the case of snake-bite with success. These rougher methods are, of course, more painful in accordance with their more efficiently destructive efficacy. But pain is a minor consideration under such circumstances, and is willingly borne by the sufferer in consideration of the far better chance of cure which accompanies it. It can be much mitigated by temporarily tightening the ligature which ought always to be bound above the affected part, wherever its application is anatomically possible; and by the subsequent application of pure carbolic acid —itself an antiseptic caustic of no mean power.—*London Med. Times.*

Heart with Two Aneurysms.—At a meeting of the Pathological Society of London, held December 1, 1885, Dr. Haig showed a specimen taken from the body of a woman aged 42, who had had rheumatic fever fifteen years before, and who had been under treatment with symptoms of heart disease. The pericardium was adherent, the cavities were dilated, foramen ovale open, mitral valve thickened; the wall of the left ventricle showed two aneursymal dilatations; the endocardium was thickened and opaque, and at the openings was markedly fibrous. Aorta showed some atheroma; the left branch of the posterior coronary artery was traced into the larger aneurysm. Microscopically, not much change was found in the myocardium near the aneurysms. There was no proof of syphilis. The occurrence in a woman was a noteworthy fact.

The Effect of Double Ovariotomy. —At a recent meeting of the Société de Chirurgie, M. Terrier read some clinical notes on the influence of double ovariotomy on menstruation. He has performed the operation twenty-two times. In some of his patients, he has been able to study their condition during ten years after the operation; in others, during one year only. One patient had menstruated from the age of 16 to the age of 22; she was aged 52 when operated on. Two others, whose general state of health was very serious, had not menstruated for several months. All the others, thirteen out of twenty-two, menstruated regularly. The two ovaries were removed, and, in most of the patients, the menstrual flow took place. In one case of single ovariotomy, the menses reappeared three months after the operation, and were regularly repeated until the remaining ovary was removed, and then they disappeared. In another instance, in which the right ovary was removed, the menses continued; the left ovary was subsequently removed, and, during five months afterwards, the menstrual flow took place regularly at the normal periods; late on, the menopause was definitely established. Three patients menstruated regularly during seven years after undergoing double ovariotomy. M. Terrier concludes that ovariotomy is generally followed by suppression of the menstrual flow. This may not occur immediately; sometimes the menses appear once after the operation, sometimes twice during the following year, sometimes four times during the three subsequent years.—*Paris Cor. to Br. Med. Journ.*

Sanitary Inspection.—The inspectors in Chicago during the first nine months of the year, made 63,264 examinations of which 51,381 were made in places ot habitation, 10,499 in factories, stores and other places of employment, and 1,384 were made according to law in new buildings in process of construction.—*Courrier of Medicine.*

A Large Turpentine Farm.—The largest turpentine farm in the world is

located at Live Oak, Florida. The owners run eight stills, over 25,000 acres of well-timbered land, employ over 300 hands (chiefly convicts), work 100 crops of boxes (1,200,000 tons), and turn out annually nearly 30,000 barrels of rosin and 6,000 (300,000 gallons(spirits of turpentine.—*Med. and Surg. Reporter.*

Proprietary Medicines in the United States.—According to the last United States' census there are 563 establishments devoted to the "proprietary medicine" business employing 4,015 operatives, with an aggregate investment of capital amounting to 10,620,000 dollars, and the annual produce is valued at 14,682,000 dollars.—*Boston Med. and Surg. Jl.*

Medical Items.

The *Medical Record* states that it is estimated that there are now in the United States 120,000 practitioners of medicine, including non-graduates.

Dr. J. P. Reynolds has resigned the Professorship of Obstetrics in the Medical School of Harvard. Dr. W. L. Richardson the present assistant to the chair will complete the course for the present session.

Dr. R. Dubois, of Paris, contends that vaseline is not a toxic substance, but, on the contrary, is digested in considerable amount, and acts as a food. Dubois' views are mainly based on experiments with dogs.—*Med. Record.*

There are in the city of Belin, ninety-eight gymnasiums; and in 1880 and 1881, of the $1,760,000 appropriated by the city for educational purposes, one thirtieth of that amount ($58,666) was expended for gymnastics.

Dr. De Forest Willard, of Philadelphia, reports in the *British Medical Journal* (December 12th, 1885,) a case of a woman, aged 40 years, from whose bladder he removed 464 ounces of urine within twenty-four hours.

The Department of Disease of Children, which has been one of the distinguishing features of the *Journal of Obstetrics*, will be discontinued after the first of the year. Dr. George B. Fowler, who has edited this department, ceases his connection with the *Journal.*

In consequence of a report on hydrophobia, drawn up by Dujardin-Beaumetz, the Conseil d'Hygiène et de Salubrité de la Seine have issued a warning to the general public that cauterising with ammonia, carbolic acid, arnica, alcohol, etc., is perfectly useless when anyone is bitten by a mad dog; the only prompt treatment is to make the wound bleed, wash it, and then cauterise.

Dr. Benjamin Lee, of Philadelphia, estimates the debit and credit account of the Plymouth epidemic as follows: Number of cases 1,153 which cost $59,100,17; hospital cases, $8,000; loss of earnings to patients and others, $30,020,08; capital represented by loss of income of 114 persons who died, $613,984; Total, $711,104,25.

Mr. Ernest Hart, the talented editor of the *British Medical Journal*, has been defeated as a candidate for Parliament from East London. The *London Medical Times* expresses the hope that he will now "return to the management of the journal which has sorely missed him of late."

Dr. C. G. Roehr, of Milwaukee, recommends in the *Medical Record* the use of peroxide of hydrogen as a disinfectant and stimulant to old ulcers and sinuses. "When injected into sinuses containing exuberant granulations it destroys these, leaving uninjured the healthy tissues. There is very little pain, and an improvement ensues.

A new monthly medical journal, entitled the *New Yorker Medinische Presse*, published in the German language, has just appeared in New York City. It is edited by Dr. George A. Rachel. The journal aims to be the organ of the German American physicians in this country. It is a creditable publication and will be found especially valuable to those physicians we are desirous of acquiring a familiarity with the German language and, especially, with its medical terms.

Dr. Albert H. Smith, one of the most distinguished of American Gynecologists,

died at his residence in Philadelphia, on December 14th, after a long and painful illness. Dr. Smith was a frequent and able contributor to the literature of his profession, and was the author of a number of valuable original articles on obstetrical and gynecological subjects. He was the originator of the Smith modification of Hodge's pessary. Dr. Smith was 51 years of age, having been born in 1835. He was remarkable for his modesty and magnaminity of character.

Twenty-five deaths from hydrophobia have occurred in London during the year 1885. The average number in the ten years 1875-84, was six. It seems a singular fact that since attention has been directed to the method of inoculation for hydrophobia by M. Pasteur, the number of deaths from this disease has markedly increased. An explanation may possibly be found in the fact that Pasteur's experiments have brought many cases into public notice which otherwise would have escaped observation and registration, or, probably, a correct diagnosis.

The *Northwestern Lancet* says that a young man fresh from college, whence he came with honors and medals, was sent by his father, a practitioner of fifty years' standing, to attend a woman in labor. On making a digital examination, he found the os uteri undilated. After waiting an hour, there being no improvement, he applied belladonna ointment, and endeavored to make forcible dilatation. At the end of another hour, there was still no dilatation; and, being alarmed, he went to his father for assistance; but before they returned the child was born. On examination, the father found that the child's anus was red and patulous, and was liberally besmeared with belladonna ointment. The young practitioner had met with a breech-presentation, and had mistaken the child's anus for an undilated os uteri.—*Boston Med. and Surg. Jl.*

A case is reported in the *British Medical Journal*, (December 12, 1885,) of a girl who died from poison administered by her sister by mistake. The attending physician ordered for the girl two remedies, one for local and the other for internal administration. The local embrocation contained a strong preparation of belledonna, but it was not labelled "poison." This remedy was carelessly given internally and the death followed in ten minutes. The jury of enquiry recorded as their verdict, death by belladonna poison administered by mistake, and that the medical attendant was not free of blame in the matter. His mistake lay in not having the bottle marked "poison."

A new article for dressing wounds, called Berthault's taffetas, has just been brought out, which is considered to be superior to the adhesive plasters hitherto used. It is as transparent as glass, and as thin as the skin of an onion; the condition of the surface covered by it is as easily seen as though it were uncovered. This plaster is as elastic as India-rubber; it cannot be traversed by fluids, and is unaffected by change of temperature. Chemically it is inert; neither changed by acids, alkalies, nor the secretions of the human organism.—*Paris Cor. to Brit. Med. Journ.*, Dec. 12, 1885.

We learn from the *British Medical Journal* that intimations have been issued to the effect that the *London Medical Times* will cease to appear after the end of the year 1885. This is one of the oldest and most valuable of the British medical publications and its suspension is to be deeply regretted by all who have been entertained and instructed by its weekly visits. The *Times* has long held a high place in medical literature and has enjoyed an enviable reputation among scientific publications. Its suspension is no doubt due to the fact that in aiming to occupy the highest plane in medical literature it has ignored those methods of trade which bring results in current funds. The *Times* has been too independent, too outspoken and too scientific to compete with its rivals for professional favor in Great Britain. Our British brethren resemble their American relatives in their high appreciation of a lollipop diet in medical journalism. The *Times* presented a highly nutritious diet, but it lacked the confectionary flavor.

Clinical Lectures.

THE POST-MORTEM RESULTS IN A CASE OF DYSENTERY.—EPITHELIOMA OF THE PYLORUS.

A CLINICAL LECTURE, DELIVERED AT THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA, BY WILLIAM PEPPER, M.D., LL.D.,

Provost of and Professor of the Theory and Practice of Medicine and of Clinical Medicine in the University of Pennsylvania.

Specially reported by William H. Morrison, M.D., for the Maryland Medical Journal.

Gentlemen:—I shall first ask your attention to these specimens which were removed from a patient who died in the hospital last night. The history of the case is as follows: The patient was 31 years of age and was admitted on November 25th, three days ago. No account of the family history could be obtained. For a long time she had been of intemperate habits. On November 9th she began to drink heavily of whisky, and continued this until one week ago. On the 18th, while still drinking heavily, she ate several apples and was seized with violent vomiting. Soon after this severe purging began. The stools were watery and of a greenish yellow color. She lost her appetite entirely and, in the course of a couple of days, the stools and the matters vomited became streaked with blood. She continued in this condition through the following week. On the night of the 24th she was out on the streets from an early hour in the evening until two o'clock the next morning exposed to a heavy rain and a cold wind. For the ten days previous she stated that she had eaten nothing but one apple, and that she had had no rest. On the 25th she started to walk from the other end of the city to the hospital. Sometime later she was found lying on the hospital grounds almost exhausted.

On admission, the whole surface of the body was cyanosed from venous congestion. When the blood was pressed from the capillaries it returned very slowly. The pupils were sluggish. The breath was cold and the surface of the body cold. The temperature in the mouth was only 92°. The heart sounds appeared to be normal, but feeble. There were frequent stools of a greasy green color, with threads floating in the liquid. Some of these looked like stercoraceous matter. There were other shreds more numerous, of a yellow color, floating on the surface of the liquid. These were of no definite shape and could be spread out. Microscopic examination of these showed them to be composed of a nucleus of mucus, surrounded by columnar epithelial cells, red blood corpuscles in moderate amount and white globules, with a great profusion of bacteria of various forms. The stools were passed almost unconsciously.

She was at once stimulated, hot applications were made to the stomach, and milk and beef-tea were administered in small quantities. Her temperature gradually rose to 98°. Efforts were then made to check the discharges by small doses of opium given every hour. In the afternoon of the 25th she had reacted and the diarrhœa had almost entirely ceased. She was then given five drops of tincture of digitalis with five grains of carbonate of ammonia every second hour. In the evening she began to doze as though from the effect of the small doses of opium which had been given. She then began to sing and talk in a rambling, wandering way and would wake up with hallucinations. About nine o'clock in the evening she became more restless, and the dose of digitalis was increased to ten drops. During the later part of the evening she tried to get out of bed, but on being spoken to she became rational. The temperature was taken through the night. It gradually rose, from 4 P. M., until it reached 101°. At midnight it had again fallen to 97°, but towards morning it again went up and reached 101°. The only times that the temperature was above normal was for a few hours on the 25th, and again last night.

Yesterday morning she seemed slightly improved, the diarrhœa was checked, the mind was clearer, but there was still a little confusion. There had been

no vomiting since admission. In the afternoon the bowels were open three times, the stools presenting the characters already described, containing disintegrated mucous membrane and blood. The surface of the body was still cold and there was still evidence of venous stasis, although less marked. Toward evening the diarrhœa again returned and the pulse became weaker. The respirations became shallow and, despite the active stimulation, she continued to sink and died at an early hour this morning. The diarrhœa was entirely checked for twelve hours preceding death. No urine could be obtained for examination, as the bladder was evacuated at the same time that the bowels were moved.

The post-mortem examination was made ten hours after death. There was well pronounced rigor-mortis. Only the abdominal and thoracic organs were examined. The heart was somewhat enlarged, but otherwise normal. There were several yellowish clots in the left auricle, aorta and pulmonary vein. There were still softer dark clots, with lighter colored lamina, in the cavities. The valves were healthy and aorta normal. Such clots, as the soft red clots that break as they are handled, are post-mortem. Others, the so-called chicken fat clots, of a light yellow color, yield ing, on pressure, a considerable quantity of serum, are produced during the death agony and are not truly ante-mortem clots and are productive of no symptoms. When we speak of a clot as ante-mortem, we mean that it is firmer than the chicken fat clot, not so thoroughly saturated with serum, tenacious and breaking up with considerable difficulty, whitish in color and often moulded to the irregularities of the surface with which it is in contact. Such characters indicate that the fibrin has separated sometime before death and the clot may have produced some symptoms, and may in part have been the cause of death.

The pericardium contained two ounces of liquid. Such an amount of pericardial effusion does not indicate any morbid condition. This is frequently found where death has followed obstruction to the circulation, leading to a little passive effusion. This is of no serious moment. Where there are large amounts of effused liquid the membrane will exhibit some evidences of inflammation. There were no signs of inflammatory change in the pericardium in this instance.

On opening the chest there were found old pleural adhesions on both sides, but particularly marked on the left side, there being almost complete union between the parietal and visceral pleura. There was no appreciable quantity of fluid in either cavity. Such old adhesions are constantly met with in post-mortems, particularly in the persons of those who have been much exposed and have suffered from slight, neglected attacks of pleurisy. These have been followed by adhesions obliterating in part or altogether the pleural cavity. This condition is of such frequent occurrence that it must be regarded as possessing very slight pathological importance. The lungs were greatly congested, but exhibited no other change. The stomach was slightly larger than normal. The mucous membrane was much congested, and numerous grey streaks are seen on its surface, looking like layers of false membrane. These are removed with difficulty. In several places little hemorrhagic spots are seen. The stomach, therefore, showed the evidences of chronic inflammation, the result of the irritating action of alcohol, which she was accustomed to take in great excess. The mucous membrane was greyish, the color which it often assumes when the seat of long standing congestion. The folds of mucous membrane were unusually prominent and unusually congested when first removed from the body. There was evident enlargement of the solitary glands, but this has now disappeared to a large extent. In some places the congestion has been followed by a little hemorrhagic infiltration. We occasionally meet with spots and streaks of dark color, like those which I here show you. Sometimes, on examining them carefully, it appears as though the mucous surface had been partly removed, so that spot is slightly depressed, and to such a spot the name hemorrhagic erosion is given.

This is really a superficial ulcer, usually of small size, the base of the ulcer being stained with blood. The examination of the base of such an ulcer shows that it is stained with chrystals of hæmatin. In the present instance there is no destruction of the mucous membrane and the spots are elevated above the surface. This is rare, but is found, especially in cases of chronic gastritis, where there has been repeated attacks of intense irritation of the stomach from excessive intemperance. There will sometimes be found a greater degree of enlargement of the papillæ than is here present. Where these are quite marked we have a mamilated condition of the mucous membrane of the stomach. This is indicative of protracted and severe chronic catarrhal gastric inflammation, which has especially affected the gastric follicles. In other cases, as here, the general mucous surfaces suffer most.

Examination of the intestine showed the duodenum deeply congested and the bile duct patulous. The jejunum was slightly congested. The ileum was more congested, and toward its lower part showed the valvulæ conniventes capped with false membrane, and this became more marked toward its lower part, so that twelve inches from the ileo-cæcal valve it was also found between the valvulæ conniventes. The whole surface of the mucous membrane of the colon was covered with this membrane except in patches where the epithelium seems to have been lost. The sigmoid flexure was comparatively healthy, but the rectum showed marked development of false membrane. There were also the lesions of previous disease of the large intestine. Here we have the lesions of enteritis and of colitis or entero-colitis. There is one form of entero-colitis which, as you know, is termed diphtheritic. This is not an entirely fortunate name, for it is only given on account of the existence of the layer of false membrane upon the diseased mucous membrane. It is not to be considered as implying that this affection has any connection with true diphtheria. It would be better to speak of this as pseudo-membranous entero-colitis.

Dysentery is a name which has been restricted to ulcerative inflammation of the rectum and colon. There are various forms of dysentery, and pseudo-membranous dysentery is not very rare. This case well shows the difficulty of drawing absolute boundary lines to these various diseases of the intestine. The term entero-colitis covers the majority of these cases. This patient had suffered from previous attacks of entero-colitis, and the bowel is contracted rather than distended. In acute cases the bowel may be distended.

The liver was enlarged, soft and friable. There were some small patches of old peritonitis, causing adhesions to neighboring organs. The spleen was enlarged, dark, but otherwise normal. The kidneys presented patches of marked injection of the pyramids. When the right kidney was opened a quantity of pus escaped from the cut end of the ureter. The capsule was adherent and the cortical substance appeared reduced in thickness. This bladder was slightly thickened and ribbed. The uterus was normal, as also were the ovaries. The right Fallopian tube contained a small cyst.

This dysentery then occurred in a woman of dissipated habits, who evidently had been the subject of gastro-intestinal disturbance as the result of her excesses. It was apparently provoked by a prolonged debauch, absence of wholesome food, the use of crude and irritating articles of diet, as raw apples, while, at the same time, large quantities of undiluted spirits were taken. To these causes are to be added exposure and exertion. It came on as a violent acute disease, under circumstances which fully accounted for its occurrence. In the commencement the stomach was distinctly affected, but it soon became evident that the chief seat of the disease was the large bowel.

A case of this kind is not very suitable for the discussion of the treatment of dysentery, but it shows in an excellent way the local lesions of this affection.

Epithelioma of the Pylorus.—The patient now before you is J. G., a farmer, who has been obliged to work hard and

has been much exposed to weather. There appears to be no other depressing influence. His meals have been somewhat irregular, but he asserts that he has eaten slowly and chewed his food carefully. He has been strictly temperate as regards the use of alcohol. There is no venereal history. The only excess appears to have been in the use of tobacco. He has been in the habit of smoking a good deal before breakfast and has chewed to excess. His family history appears to be fairly good. He has had the ordinary diseases of childhood. He had typhoid fever many years ago; otherwise, he has been in good health, with perfect digestion, until eleven months ago. Then he was taken rather suddenly, without ascribable cause, with severe lancinating pain, beginning in the region of the umbilicus and radiating up into the left side of the chest. This pain came about the middle of the forenoon, and would continue until vomiting of a sour, watery material occurred. This ended the pain. The bowels became constipated and the stools consisted of hard masses. Unless he was extremely careful in regard to his diet, the taking of food was followed by discomfort and dyspeptic symptoms. The ingestion of food never brought on the pain. For three months he vomited at least once a day, and the pain continued to increase in frequency and severity. The vomiting then became less frequent but the other symptoms persisted. Lately, the vomiting has again returned. He has lost considerable flesh, become pale, anæmic and very weak. For the last few weeks he has noticed some fluttering of the heart on exercise.

Returning to the spells of pain from which this patient suffered, it will be observed that they came on, not after the taking of food, but about the middle of the forenoon; secondly, that the pain increased until it brought on vomiting, which gave relief. He also found that the pain was relieved by pressure and also by drinking hot water. His general appearance may be described as follows: He is thin, stooped in posture, hair grey, and he looks fully his age, pale, expression anxious, tongue coated a little posteriorly, teeth rather poor, bowels costive. We notice a piece of adhesive plaster on one side of this man's nose, and on removing that, we find a small epitheloma. The abdomen is not much distended, but the stomach is, and the peristaltic movements of the organ can be plainly seen. Some tenderness is complained of on deep pressure over the epigastrium.

Here then is a case in which it might be said that the most marked symptom is the attacks of pain. This pain, in some respects, resembles the pain of gastralgia. The pain does not come on immediately after the ingestion of food, as does the pain of ulcer or of gastritis. It resembles the pain of gastralgia in being relieved by pressure and by the ingestion of hot water. On the other hand, it differs from ordinary attacks of gastralgia, in the fact, that it goes on until it induces vomiting, and this is the only thing that gives complete relief. This man has suffered more in his general health than could be attributed to simple gastralgia. This change has been brought about in eleven months. Again, there are evidences of some pyloric obstruction. The vomiting comes on sometime after the ingestion of food and this relieves the pain. We know that in obstruction of the pylorus, when digestion has reached a certain point, the organ is irritated, pain is excited, the efforts are renewed and, finally, so much irritation of the stomach is produced that vomiting occurs and relief is afforded. There has been, in this case, marked constipation of the bowels. As the surface of the abdomen is watched the waves of peristalsis can be plainly seen passing over the stomach. These movements are most markedly seen in cases of dilatation of the stomach from obstruction of the pylorus. I do not assert that these symptoms establish the existence of pyloric obstruction. It is quite possible that dilatation of the stomach may occur as an idiopathic condition. It may also result from chronic gastritis or from the habitual over-distention of the stomach from the ingestion of excessive quantities of food or from excessive weakness and relaxation of the walls of the stomach.

Does this man present any of the

causes which would lead to idiopathic dilatation of the stomach? I scarcely find them. He has eaten slowly, masticated his food well, and has not been a gluttonous person. There have been no excesses that would give rise to chronic gastritis. Previous to eleven months ago he suffered from no grave gastric symptoms. His general condition was good. His temperament, his age and his general condition were such as to make it unlikely that he should suffer from a neurosis. There is nothing but the excessive use of tobacco which would lead us to suspect grave functional disorder of the stomach. In this case much importance cannot be attached to the use of tobacco, for he has used it for forty years and there is no reason why it should suddenly begin to produce such grave symptoms as he has manifested. The fact that the pain is relieved by pressure and by hot water is unusual, but it is not wholly unreasonable, even on the supposition that there is positive organic obstruction of the pylorus.

We have then pain coming on sometime after eating, relieved by vomiting, constipation of the bowels, dilatation of the stomach, visible peristalsis, and rapid and progressive emaciation. While these symptoms are not absolute proof of the obstruction of the pylorus, yet where we can find no adequate cause for dilatation of the stomach, they may be taken as affording almost sufficient evidence that the pylorus is the seat of organic trouble.

The conclusive proof that such was the case would be the detection of a tumor in the region of the pylorus. There is no distinct tumor, but in the region of the pylorus, there appears to be a hardness. I have referred to this little spot on the left side of the nose. As is well-known, epithelioma of the stomach frequently follows cutaneous epithelioma. The existence of this little spot on the face is an important link in the chain of evidence which makes me regard this as a case of gastric epithelioma, situated in the neighborhood of the pylorus, which it partially obstructs, thus giving rise to the dilatation of the stomach and the other symptoms.

Gastralgic pain is to be found in the early stage of not a few cases of malignant disease of the stomach, so that for weeks, and even months, you may be led to hope, and even believe, that you are dealing with a functional disorder of the stomach. In this case the group of symptoms, which I have described, the steady progress of the case, the presence of cutaneous epithelioma, and the abscence of adequate cause for dilatation of the stomach, are sufficient to justify the belief that there is developing epithelioma of the stomach, although it would not justify the expression of such an opinion to the patient.

The case, however, must be treated as one of functional disorder. We shall place this man on a diet consisting largely of wine whey, rennet whey, strained gruel and broth. Of these he will be given a small quantity every hour. I shall order a mixture containing two drops of dilute hydrocyanic acid and one drachm of elixir valerianate of ammonia to be taken four times a day, soon after eating. Externally, I shall apply a strong ointment of veratria, of sixty grains to the ounce, over the epigastrium. I shall have a faradaic current of electricity applied, with one pole over the pneumogastric nerve in the neck and the other over the epigastrium. The man will be kept quiet, and allowed to exercise but little, for living on such a low diet, any degree of exercise will be injurious. This treatment will be continued, and if this is a functional trouble, there should be some improvement in the course of a couple of weeks. I fear, however, that the natural progress of the case will verify our suspicions.

Professor Da Costa treated a case of *goitre* with syr. ferri iodidi, gtt.xx ter die, and local applications of the official ointment of iodide of mercury.

Another case of the same was given tinct. aconite gtt.ij ter die, with ice locally.—*Col. and Clin. Record.*

Not a "Complication of Disease."—Medical Examiner: What did your father die of? Appliccant: Oh, just *plain* death.—*Med. Record.*

Selected Articles.

PURE TEREBENE IN THE TREATMENT OF WINTER COUGH.*

BY WILLIAM MURRELL, M.D., F.R.C.P.,

Lecturer on Pharmacology and Therapeutics at the Westminster Hospital; Examiner in the University of Edinburgh and to the Royal College of Physicians of London.

There are few complaints which interfere so seriously with the duties and pleasures of life, without actually incapacitating the sufferer, as chronic bronchitis. The disease is essentially chronic in its course; and the patient, if a resident in London, is rarely free from his enemy for more than a few weeks in the heigth of the summer. With the first fog or the first touch of cold east wind, the cough returns with its attendant discomforts, not to depart until the following spring is far advanced. Year by year, it comes back with tantalising punctuality, and lingers on with all the pertinacity of an old friend or a poor relation. During the last five years I have employed a method of treatment which yields excellent results. I have before me notes of 114 cases of winter cough, some taken at the Chest Hospital, others at Westminster, and others again in private pratice. They were all treated with pure terebene, a substance prepared by the action of sulphuric acid on oil of turpentine. It is an agreeable remedy, being a clear colorless liquid, with an odor like that of fresh-sawn pinewood. It will not mix with water, but, as the dose is small, it can readily be given on sugar. It is not the same as the patent medicine sold under the name of "Terebene." The best method of indicating its sphere of action and illustrating its utility will be to give a brief abstract of the notes of the cases. This, it should be said, is a fair average case taken quite at random.

R. N., aged 43, a commercial traveler, stated that he had been subject to cough every winter for twelve years. His work was against him, and he was a good deal exposed to wet and cold and the inclemency of the weather. His cough used to trouble him badly only in the winter, but, year by year, it seemed to be coming on earlier, and now he was hardly free from it. It came on in fits, which shook him to pieces, and it was always very bad the first thing in the morning, often making him retch and vomit. There was a great deal of phlegm, thick and yellow when he was in the country, but speckled all over with black in London. It was difficult to get up, unless he could get some hot tea or something to loosen it. The shortness of breath was worse than all, for it prevented him from going about, and interfered with his business. He had never spat any blood worth speaking of, but there were at times streaks after a severe bout of coughing. He becomes no thinner, generally loosing a little in the winter, and picking up again in the summer. He had had a great deal of treatment, and mixtures, lozenges, and liniments, without end. On examining the chest, it was found to be emphysematous, and there was a loud bubbling rhonchus at the base of each lung. On November 1st, he was ordered ten drops of pure terebene on a piece of surgar every four hours. In three days, he returned, and said there had been a marked improvement; the cough was easier, the phlegm was lighter in color and not so thick, and the breathing was decidedly better. The dose was increased to twenty minims every four hours; and, a week later, the patient wrote to say that he was better than he had been for years, and was almost able to do without the medicine. I saw nothing of him again until January 6th, when, being in town, he came to see me. There had been some return of the old symptoms, and he was anxious for further treatment. I ordered him a small Maw's spray-diffuser, holding about an ounce, and instructed him to use it with the terebene as an inhalation several times a day. A fortnight later, he wrote, saying that he bought a larger apparatus, and that his complaint was more amenable to treatment than it had

*British Medical Journal, Dec. 12th, 1885.

ever been before. The terebene-spray eased the cough, brought up the phlegm, and, above all, relieved the shortness of breath. On his long railway-journeys, when he was unable to use the spray without inconveniencing his fellow-passengers, he rubbed the terebene on his moustache and beard, so that it might slowly diffuse, and, as he said, "softened the atmosphere."

One of the great advantages of pure terebene is, that it is not a bulky medicine. An ounce bottle, carried in the pocket, will last for days, and is always ready for use. It is best to begin with five or six drops on sugar every four hours, and gradually to increase the dose to twenty minims. This is, for most people, the maximum quantity, but the drug has little or no toxic action, and one patient was so enraptured with his remedy that he insisted on taking a teaspoonful every four hour for a week. The only disadvantage I have ever noticed from its employment is that it gives a peculiar and characteristic odor to the urine, a circumstance which patients never fail to mention. When used as a spray, from one to two ounces should be diffused and inhaled every week. In some instances, I have tried giving it mixed with equal quantity of olive-oil flavored with peppermint. In twenty-five cases I gave the terebene in the form of an emulsion, made, if I remember rightly, by mixing it with a little tragacanth powder, adding water and shaking well. Each ounce of the emulsion contained a drachm of the terebene, and it was usually given in half-ounce doses four times a day. The results were excellent, but no better than with the simple terebene itself, and I saw no reason for continuing the use of a more expensive preparation. In every case of winter cough in which the terebene-spray was used systematically, there was a marked improvement. In many instances, it was noticed almost immediately; but in other cases, especially the very chronic ones, the patient had to continue using his remedy for some weeks. Even when there was marked emphysema, with little movement of the chest walls, some benefit was experienced. I treated eighteen cases of phthisis by the same method, and the results were certainly most encouraging. It did most good when there was old consolidation, when no active mischief was in progress, and especially when there was no elevation of temperature. I have also used it as a dry antiseptic inhalation on the cotton-wool of a respirator in phthisis, and have been much pleased with the results. In one case, that of a young lady, the respirator was worn almost continually night and day for nine months; and the right lung, which was breaking down, cleared up, the temperature becoming normal, and the cough and other symptoms subsiding. I have no doubt that pure terebene would be useful in checking hæmorrhage from the lungs, but on that point I have no experience.

Many sufferers from winter-cough also complain of acidity and flatulence. I soon found that the internal administration of pure terebene was an excellent remedy for this combination of symptoms. It checks the formation of flatus so quickly, and is so efficacious in expelling any that may remain in the stomach or intestines, that I constantly employ it in cases of dyspepsia when flatulence is a prominent symptom. Patients like it, and often continue the taking it for months or years. It acts as an antiseptic, probably in much the same way as glycerine, oil of cajeput, and oil of eucalyptus. I am surprised that it has not come more largely into use in the treatment of flatulence.

Pure terebene is of such value in winter-cough, that I rarely experience the necessity of resorting to other remedies. This year, however, I have tried a combination consisting of equal parts of pure terebene, oil of cubebs, and oil of santal wood, mixed with liquid vaseline. This I use in an atomising apparatus invented by Mr. W. F. Semple, of Ohio—an apparatus which is somewhat complex and difficult of description, but may be said to consist essentially of a jar in which the medicated fluid is finely atomised by a blast of air propelled by a rubber-ball. A nose-tube is attached, and the fine spray inhaled either through

the mouth or nostrils. It is certainly one of the best forms of spray-apparatus ever invented, and when used with a cucaine-solution, will be found wonderfully efficacious in the treatment of hay-fever and coryza. The formula I have given yields excellent results, not only in winter-cough, but also post-nasal catarrh. I have made some observations on this point, in conjunction with a well known tenor, and have been astonished to note what a marvellous difference there is in the tone of his singing-voice after using it for only a few minutes. It is a powerful expectorant; and if inhaled the first thing in the morning, when the mucous membranes are covered with thick viscid secretion, will give very great relief. Pure terebene is a valuable remedy, and will in time come largely into use.

Hospital Reports.

ANNUAL REPORT OF THE WORKING OF THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL.

BY JULIAN J. CHISOLM, M.D., SURGEON IN CHARGE.

The year 1885 has been very prosperous for hospital work at the Presbyterian Eye, Ear and Throat Charity Hospital. The records show 6,027 new cases entered on the books against 4,579 for the year 1884, and of house inmates 483 against 279, with 5,786 days of hospital treatment against 3,088 for the year 1884. Of the 6,027 new cases, 4,291 were eye patients, 900 suffered with throat disease, and 836 with deafness. This large increase in the attendance has made busy work for the entire year and makes this institution one of the very large eye hospitals of the country. The daily attendance shows an aggregate of 27,258 persons, or an average of 89 patients for each day of the year.

The working of the Hospital in all of its departments has been smooth, leaving the inmates but little to desire. The ventilation of the building is perfect, so that the atmosphere of the house is always taintless. This excellent sanitary condition, combined with careful nursing and good food, has exhibited the most valued results in the large percentage of successful operations, and the marked rarity of failures. There were 1,220 operations performed during the past year against 742 for the year 1884. The daily use of cocaine has proved itself very valuable, not only in preventing pain during the most delicate operations on the eye, but also in expediting the cure. Under its liberal application inflammation seldom follows upon operations, and the blind cataract patients have the gratification of leaving the Hospital in the enjoyment of restored sight after a painless treatment of two short weeks. These operations in healthy subjects are so nearly uniformly successful that they no longer cause anxiety. Among the 129 cataract operations of the past year the youngest patient, needing an operation on each eye, was only one year of age. The oldest was 89 years of age. Between these extremes every age was represented.

The private rooms of the Hospital have been in constant demand, and at times have been all simultaneously in use with patients awaiting vacancies. These private apartments, so handsomely furnished by the generosity of private persons, promise to become a permanent source of revenue and an aid to the support of some of the charity beds in the Hospital. At one time nearly every Atlantic State was represented by the occupants of these private apartments from New Hampshire to Florida.

Of the 6,027 new patients treated during the year 1885, 5,380 were white and 647 were colored.

The Presbyterian Eye, Ear and Throat Charity Hospital is doing a good work for this section of country in not only relieving the suffering of a large number of working people, but in disseminating a better knowledge of eye diseases and their treatment among young practitioners of medicine; and very much needed information it is. Recently, on the same day, four infants, from three to five weeks old, were brought to the Free Dispensary for treatment. Two of these were twins. Three days after birth the symptoms of purulent ophthalmia of the

newly born had set in. Under judicious treatment this dangerous disease would have been surely and promptly checked. These children had been seen daily by the attentive family physician, but not understanding this apparent case, and for want of the necessary knowledge how to treat these cases, seven of the eyes had been destroyed by perforating ulcers of the cornea, and the eighth was just about going out, without the attending physician being aware of the accident. Fortunately, this one eye had not yet yielded to the baneful influences of the poison, and a few days of judicious treatment brought it into a condition of safety, but the other seven eyes were lost beyond recall. Here at least are three blind infants who must become for all their remaining lives wards of the public, to be cared for at the expense of the State at a cost of thousands of dollars to tax payers, where blindness could have been easily prevented. Such sad cases multiplied themselves quite frequently during the year's experience. Sometimes they are brought to the Hospital when only a few days old, and therefore in time to be cured; then again, as in the instances quoted, when too late to derive any benefit from treatment. These blind infants must in time become the inmates of blind asylums and alms houses.

It is said that one-half of the blind pauperism of the world, necessitating expensive institutions for their partial education and the outlay of millions of money for their support, is the result of diseases of easy control when properly treated. A little knowledge if generally disseminated among medical men will prevent untold misery to thousands of our fellow creatures.

Correspondence.

PHILADELPHIA, Jan. 2, 1886.

Editor Maryland Medical Journal.

DEAR SIR:—On page 168 of your JOURNAL, (December 25th,) I find some remarks attributed to me which need correction.

I did not refer to Hypocrates. I did not state that Hippocrates "removed from a patient under his care forty tumors of this calcareous character;" but that he spoke of a Thessalian servant who at two different times passed from her womb what we now would know as calcified fibroids. I did state that in one case some forty uterine fibroids which had undergone calcareous degeneration were found upon post-mortem examination. The case given at the conclusion of the remarks, of a woman who passed a sewing needle from the uterus, was not stated to be under my care.

I trust that any other medical Journals that may publish the proceedings of the Philadelphia Obstetrical Society, will correct these mortifying mistakes.

Sincerely,

THEOPHILUS PARVIN.

BOOKS AND PAMPHLETS RECIEVED.

Hand-Book of the Diseases of the Nervous System. By JAMES ROSS, M. D., LL.D. Fellow of the Royal College of Physicians of London, etc. With One Hundred and Eighty-four Illustrations. Philadelphia: Lea Brothers & Co., 1885. Octavo. 708 pages: Cushings and Bailey, Baltimore.

A Treatise on the Diseases of Infancy and Childhood. By J. LEWIS SMITH, M. D., Clinical Professor of the Diseases of Children in Bellevue Hospital Medical College, New York. Octavo. 876 pages. 40 Illustrations. Cloth $4.50; Leather $5.50. Philadelphia: Lea Brothers & Co., 1886.

The Field and Limitation of the Operative Surgery of the Human Brain. By JOHN B. ROBERTS, A.M., M.D. Professor of Anatomy and Surgery in the Philadelphia Polyclinic, etc. 78 pages, Illustrated. Philadelphia: P. Blakiston, Son & Co., 1885.

Puerperal Convalescence and the Disease of the Puerperal Period. By JOSEPH KUCHER, M.D. 311 pages. New York: J. H. Vail & Company, 1886.

Nephrolithotomy. By L. MCLANE TIFFINY, M.D., Professor of Surgery in the University of Maryland. Extracted from the Transactions of the American Surgical Association, Vol. III, 1885, pages 13. Philadelphia: Collins, Printer, 1885.

Practical Suggestions Respecting the Varieties of Electric Currents and the Uses of Electricity in Medicine. With Hints Relating to the Selection and Care of Electrical Apparatus. By AMBROSE L. RANNEY, M.D. Professor of the Anatomy and Physiology of the Nervous System in the New York Post-Graduate Medical School and Hospital, etc. 147 pages. Illustrated. New York: D. Appleton & Co., 1885.

Essentials of Vaccination. A Compilation of Facts Relating to Vaccine Inoculation and its Influence in the Prevention of Small-pox. By W. A. HARDAWAY, M. D., Professor of Diseases of the Skin in the Post-Graduate Faculty of the Missouri Medical College, St. Louis. 138 pages. St. Louis: J. H. Chambers & Co., 1886.

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BALTIMORE, JANUARY 9, 1886.

Editorial.

THE TREATMENT FOR RUPTURED TUBAL PREGNANCY.—The occurrence of extra-uterine fœtation is always attended with great anxiety. In former times it was justly regarded as the forerunner of almost certain death. The few patients who survived the results of this condition of pregnancy made their escape by those fortunate chances which nature not rarely invents to prolong the end of life.

The treatment of extra-uterine fœtation has been so improved by recent operative methods that a new hope has been extended to woman by the well-advised labors of modern surgeons. Indeed, the triumphs now achieved in terminating fœtal life as it develops in abnormal situations and in removing the products of conception by abdominal section are not surpassed in any other field of surgery. Through the agency of electricity the destruction of the fœtus is now a successful and easily accomplished result. The contributions to this method of dealing with tubal, interstitial and abdominal pregnancy come into notice with such frequency that the profession is surprised by the brilliancy of the results secured. The management of the varieties of abnormal fœtation resolves itself into a question of diagnosis. The doubtful method of dealing with this condition can hardly be said to have a fair existence. Let the physician or surgeon once be sure that abnormal gestation is going on and the method of dealing with the grave problem is at once suggested. The policy of holding hands off and watching for nature to suggest the line of treatment cannot be said to have a claim to consideration. The surgery of to-day says "be up and doing," and with this motto the surgeon is prepared to deal with a condition—at one time almost hopeless—now full of brilliant promise. The results of delay in dealing with extra-uterine pregnancy are manifested at times in most alarming surprises and accidents. In the tubal pregnancy a rupture of the sac has had in the past a terrible mortality. A sudden shock, a collapse and agonizing depression announce the fatal end of a life which may have had happy longings for a maternity unclouded by such anticipations. The older members of the profession may be able to recall an experience such as we attempt to picture. Abundant proof is at hand to show that this terrible accident is within the curative power of the surgeon, provided, that the fatal delay, which has hitherto been the rule in dealing with abdominal and pelvic disease, be eliminated.

We have before us the record of twenty-three operations for ruptured tubal pregnancy with twenty-two cures and one death. All of these operations are reported by Mr. Lawson Tait, (see *British Medical Journal*, Dec. 19, 1885) of Birmingham, England.

We present Mr. Tait's own statement of the facts as it is written in the clear and forcible language of this bold and skillful surgeon. We pass his remarks without further comment, as they have sufficient merit to receive proper consideration:

"The leading features of all the cases in this series have been already described so completely in detail in my previous papers, that I need not do more than recapitulate them here. The history of nearly all is, that the patients have either never been pregnant before, or that a long interval has elapsed since the last paegnancy; that menstruation has been, as a rule, before the occurrence of the

tubal pregnancy, of such a character as to lead to the inference that there was some tubal disease; that menstruation has been arrested for a period of ten or twelve weeks before the incidence of the serious symptoms which led to the interference; and that, during that time, more or less discomfort, or even serious distress, was felt. Thus, in the case in which I was associated with my friend, Mr. Vickers Whitby, we had, after careful consideration, determined to open the abdomen some days before the catastrophe or the rupture occurred. The tubal rupture took place some few hours before the operation was performed. The symptoms were suddenly and intensely increased in severity; and, when the abdomen was opened, we found it full of blood-clots and serum.

In all of the operations, the hæmorrhage during the proceeding was extremely severe; and, from the lesson which I learned in the first case, that in which I failed, I am quite satisfied that rapidity in performing the necessary manipulations is an essential factor in success. In that case of failure, I was so alarmed by the amount of bleeding, that I did not act with sufficient energy; for I have since found that, as soon as the detachment of the adhesions is complete, a very small amount of sponge-pressure will arrest the bleeding. In this unfortunate case, I proceeded hesitatingly; and the result was, that the patient hardly survived the performance of the operation—certainly never rallied from it; and yet it was not, in its details, in any way different from the other cases. These adhesions occur to everyone of the pelvic vescera; and there can be little doubt that, for success in dealing with them, very considerable experience with the finger-tips will always be necessary, for it can only be after prolonged acquaintance with the sensations which are conveyed by different structures to the fingers, that the adherent tube and placenta can be recognised from coils of intestine, broad-ligament, and uterus.

The recoveries of all these cases have been complete and easy, and no class of operation in which I am concerned has given me so much satisfaction as this. The appearances on the operation-table so forcibly remind me of my old experiences of these cases in the *post-mortem* room, that I can hardly doubt that most of them, if not all, are examples of the advantage of the modern doctrine of opening the abdomen promptly in times of serious trouble."

The Therapeutic Action of Theine.—Of late years considerable attention has been drawn to the physiological and therapeutical action of caffein and theine—the active principles of our common beverages coffee and tea. It is generally admitted that within certain limits their physiological action is to stimulate the nervous system and to check tissue waste. If used habitually to excess, coffee and tea are apt to cause disorders of digestion and derangements in the nervous system, summed up under the general term nervousness.

Therapeutically, caffein has been used as a substitute for digitalis, both as a cardiac stimulant and diuretic. It and theine are also extensively employed in the rather indefinite disease "nerve-exhaustion." These two active principles are generally considered to be identical chemically and physiologically. Recent investigations have shown, however, that they differ in at least part of their physiological effect. Dr. Thomas H. Mays, of Philadelphia, has conducted some experiments to determine the effects of theine and caffein upon the nervous system. An account of these experiments appeared in the *Therapeutic Gazette* for September, 1885. We have before us the *Medical News* of December 12, 1885, which contains a second article from Dr. Mays, entitled "The Therapeutic Action of Theine; A New Analgesic." The author of the paper first presents the following conclusions concerning the physiological action of theine upon the nervous systems of the lower animals, drawn from the experiments already alluded to: (1) "It (theine) paralyses sensation before motion; (2) it impairs sensibility from the centre to the periphery, and not, like brucine and cocaine, from the periphery to the centre; (3)

it produces convulsions, which are spinal and not vertebral; (4) it has a more powerful action on the censory nerves, and less on the motor nerves than caffein." Dr. Mays' next step was to try the physiological action of theine upon the healthy human being. For this purpose he made hypodermic injections of the drug and found that there was "a general agreement in the symptoms which developed." He gives in full the details of one case in which "one-fifth grain of theine was injected into the left forearm near the elbow." In six minutes there was "diminished sensibility extending as far as the hand." Three minutes later the "sense of touch was impaired in tips of fingers." The impairment of sensation around and below the point of injection steadily decreased, and in fifty minutes atter its adminstration sensibility was absolutely gone around seat of injection." Sensibility was not entirely restored for six hours after the injections, and became *normal in the forearm* while the *tips of the fingers* were still numb. There was not at any time any impairment of motion *above* the elbow. Motion was not affected in the least, there was no difference in the temperature of the two hands, the pupils were unaffected, pulse remained steady, and there was no constitutional disturbance whatever. The only unpleasant symptoms were slight burning at the seat of injection (which soon passed off), the prickly sensation of a limb when it is "asleep," and the occurrence of "slight shooting pains along the posterior part of the arm above the elbow," occurring thirteen minutes after the injection had been given.

The objective physiological action being apparently the same that had been observed in the lower animals, he was led "to believe that theine would be efficacious in the treatment of painful affections of the long nerves." To determine its efficacy, he tried it in two cases then under his care. The first was a case of constant pain in right leg from hip to foot which had lasted six months. The pain followed the course of the nerves of the leg. The leg was considerably atrophied, and was weak and uncertain in its gait. For two months all forms of treatment had been without avail, and on July 18th he injected one-fifth grain of theine into the calf of the leg. The pain ceased in five minutes and never returned in its original force. In half an hour the heel and foot began to feel numb and insensible, which lasted for about twelve hours. Two days later Dr. Mays injected one-fifth grain into the thigh. One week later one-fifth grain was injected over instep, and the patient was then free from pain till September 6th, when a last injection was given. From that time on she made an uninterrupted recovery; the leg began to fill out, and at the present writing is of the same dimensions as the left."

The second case was one of pain in right shoulder, extending from right side of spinal column along the arm to the tip of her fingers. There was "great tenderness on pressure over right brachial plexus." After the persistent use of other remedies had failed, he "injected one-fifth grain of theine over right brachial plexus." In ten minutes the "neuralgic pain in the back was relieved;" in fifteen "the diminution of sensibility had extended from shoulder down the arm," and in twenty "anæsthesia was marked around seat of injection." In forty-eight hours there was no return of pain.

Concerning the dose of theine, Dr. Mays remarks that "in one-tenth, one-fifth and even one-third grain doses it is entirely free from dangerous consequences, and that the only inconvenience which it causes is a slight but transient burning at the point of introduction."

It will not do to at once accept unconditionally Dr. Mays' conclusions that theine is "a powerful anodyne without producing any intoxication of the higher nerve centres." The data hardly seems to us justify it. His therapeutical results, however, are so directly in consonance with his physiological investigations, that we have thought it proper to call the attention of our readers to the details of his work. We hope they will investigate this power of curing "*painful* affections of the long nerves," which is claimed, with apparent justice, for theine.

Abstracts and Extracts.

On the Difficulties of Diagnosis in Ulcer of the Stomach.—At a meeting of the Medical Society of London, held November 30, 1885, *British Medical Journal*, Dec. 12, 1885, a paper was read on this subject by Dr. Stephen Mackenzie, who said that, while the diagnosis of ulcer of the stomach was common enough, occasions of testing its correctness were comparatively rare. It had to be borne in mind that cases presented themselves where an ulcer did exist, without giving rise to any particular or characteristic symptoms; and, on the other hand, there might be a complete clinical picture of gastric ulcer, without any such ulcer being discoverable at the necropsy. Patients suffering from apepsia nervosa might conduct themsleves in every respect like one suffering from genuine gastric ulcer. This condition was one, he said, characterised by absolute incapacity of the stomach to retain and digest food due to nervous causes. The author insisted on the fact that, in cases of nervous origin, any kind of food would probably be alleged to cause pain, even, milk; and this, he said, was not generally the case in true gastric ulcer.—The President, Dr. Ord, said that, after Dr. Mackenzie's paper, he was inclined to think that cases of apepsia nervosa were pretty common. He asked whether the craving for peculiar aliments, often of an eccentric kind, such as Dr. Mackenzie had mentioned in one of his cases, had any diagnotic importance. Dr. Ord said he had been struck by the disproportion which so often existed between the lesions and the symptoms to which they gave rise; extensive lesions sometimes causing but slight symptoms, and at other times insignificant lesions would set up quite a grave train of symptoms.—Dr. C. H. F. Routh said that the temperature of the food afforded a valuable diagnostic sign; that in gastritis and ulceration cold drinks were soothing, whereas in nervous cases only warm drinks had that effect. He thought, too, that the increased tenderness over the site of an ulcer, on passing an electrical current, might be turned to account.—Dr. Sansom mentioned the case of a medical man where an ulcer of the stomach which caused death was diagnosed as commencing pleurisy, owing to the absence of definite symptoms pointing to the stomach as the organ affected.—Mr. James Black and Dr. W. H. White quoted cases bearing out Dr. Mackenzie's views.—Dr. Theodore Williams insisted on the very localised tenderness in gastric ulcers.—Dr. Angel Money suggested that the condition of apepsia nervosa should be regarded as the disease present in all cases, and that the ulcer should be considered accidental. The diversity of results would be thus explained.—Dr. T. Stretch Dower thought inquiries should be made with the view of ascertaining whether there existed any connection between cases of gastric ulcer and ataxia.—Dr. Fowler said that many cases diagnosed as gastric ulcer were attributable to organic disease of the heart.—Dr. Mackenzie, in reply, said that no symptoms could be regarded as pathognomonic. He did not think that gastric ulcers had any connection with ataxia, nor could he admit the probability of Dr. Angel Money's ingenious suggestion.

The Treatment of Pleurisy in the Bellevue Hospital.—Dr. S. Mitchell, writing in the *Theurapeutic Gazette* for November, states that about 150 cases of pleurisy are treated annually. It is rare to meet with true cases of acute pleurisy, except when it occurs in patients while in the hospital. When a case, however, is seen within the first few hours, opium is given, usually as Dover's powder or as Majendie's solution hypodermically, which, besides relieving the pain and nervous manifestations, to some extent checks the determination of blood to the pleura. The bowels are opened by salines, and mustard or turpentine applied to the chest. The pain caused by the movement of the chest is greatly relieved by strips of adhesive plaster. Tincture of aconite is given in half-minim doses every fifteen minutes for two hours, and afterwards every two hours until the pulse shows signs of becoming feeble. Quinine in doses of 10 grains

every six hours is given during the first twenty-four hours. When the state of effusion occurs the patient is made to take freely of a bitartrate of potash solution as a diuretic, the saline cathartics are continued, and iodine is applied locally. Another form of local application, which is a favorite with some, is the punctuated cauterisation with Paquelin's cautery every other day. Tonics are given and continued into the third stage, the following formula being that usually prescribed: Strychniæ sulph. gr. i, liq. pot. arsenit. ʒ ij, cit. ferri et quiniæ ʒ iv, glycerinæ aq. cinnam part. equal. ad ℥ viii; a dram after meals. With this is often given an ounce of whiskey three times a day. A dram of the following mixture is also given occasionally to allay the cough: morph. sulph., pot. cyanidæ gr. ij, syr. tolut., syr. prun. virg. part. equal. ad ℥ ij. Blisters are seldom employed. When the effusion is great enough to cause much dyspnœa paracentisis is performed at the mid-axillary line of the sixth interspace, the fluid being withdrawn slowly and arrested at the moment when the patient begins to cough or feel other unpleasant symptoms. In the chronic form of the disease the patient is put on diuretics, tonics, and mild cathartics, and counter-irritation is kept up by Corson's paint, made of ol. tiglii ʒ ij, ætheris ʒ iv, tr. iodin. co. ad ℥ ij. This painted on every morning produces a crop of pin-head blisters with very little annoyance. When absorption does not occur, this has seemed in many cases to become stimulated by aspiration, a few drams of liquid being removed by means of a hypodermic syringe, this often rendering paracentesis unnecessary.—*London Med. Times.*

Notes toward the Formation of Clinical Groups of Tumors.—Mr. Jonathan Hutchinson, of London, says, in the January number of *The American Journal of the Medical Sciences*, that, in his opinion, the time has arrived when it is both possible and desirable to make, for practical purposes, a much more detailed classification of tumors than has yet been attempted. Some grouping of the kind is needed, both for purposes of prognosis, and in order that we may lay down good rules for treatment. Such grouping must be accomplished chiefly by observation of external features of similarity, and of resemblance in general tendency. It is these conditions, rather than minute histological differences, which will be of chief assistance to the surgeon; or, perhaps, it may be convenient to have two classifications side by side, the one clinical the other histological, and let the two help each other at all points where mutual help is possible.

Mr. Hutchinson does not attempt the ambitious task of presenting an arrangement of new growths based upon their clinical features and like histories. He is, however, so convinced both of its desirability and of its practicability in the future, that he ventures to offer a few hints and detached memoranda, which may possibly prove helpful toward its attainment at some future time.

Lanolin, a New Ointment-Basis.—Dr. Oscar Liebrich reach a paper on Lanolin before the Berlin Medical Society, on October 28th (see the *Berliner Klin. Wochensch.*, No. 47). This substance is a mixture of cholesterin-fat (from keratin-holding tissues, such as sheeps' wool in particular), and water. The pure cholesterin-fat stands, as Berthelot has said, between a resin and a fat, but is capable of taking up its bulk of water. It is perfectly neutral, and possesses properties which are not shared by the ordinary fats, nor by vaseline. In contrast with ordinary fats, lanolin with difficulty decomposes, and, which is its chief property therapeutically, it is extremely readily absorbed by the skin. It is, in fact, the natural fat of the skin, and of epidermic tissues generally, such as hair, hoofs of horses, feathers, etc., from all of which it has been obtained. As a proof of this high power being absorbed, a 5 per cent. carbolic acid ointment made up with lanolin, produced a feeling of numbness, without irritation, in the hand, in from one to two minutes after being rubbed in.

The presence of cholesterin-fats is easily ascertained by Liebemann's cholestol test. The fat to be tested is dissolved in acetic anhydride (not glacial acetic acid). The solution gives a rose coloration, passing very quickly into dark blue and green when concentrated sulphuric acid is added. Glycerine-fats do not give this reaction. The advantage of lanolin over vaselin and such paraffin derivates consists in its ready absorbability. Vaseline, as is well known, greatly hinders the absortion of therapeutical agents. It is an advantage to add 5 or 10 per cent. of ordinary fat or of glycerine to lanolin so that the unctuous character may be better preserved.—*Br. Med. Jl.*

The Cause of the First Sound of the Heart.—An interesting note on the cause of the first cardiac sound, by Dr. Gerald Yeo, and Dr. J. W. Barrett, has appeared in the *Journal of Physiology*. Opinions, as is well known, have varied considerably on this point. Some observers, as Halford and Billing, looking at the relative size of the auriculo-ventricular and semilunar valves, have held that the sudden tension of the former is sufficient to produce the first sound of the heart. These observers point to the fact that just as the act of hooking back one semilunar valve abolishes the second sound, so the same act of hooking back one auricular valve, or the incompetence of the valve as a whole, impairs or abolishes the first sound; and they also point to the fact the tracing of a cardiac contraction is a single contraction, and not a tetanus of the muscular tissue. Many careful experimenters, however, maintain that the muscular sound must be regarded as an element in its causation, and insist on the greatly increased volume of the sound in cases of cardiac hypertrophy. Drs. Yoe and Barrett's experiments originated in a difference of opinion between them on this point, each being desirous of persuading the other of the soundness of his views. To determine the question, a large cat and an active mongrel bull-terrier where chloroformed and subjected to artificial aspiration, and the cardiac sounds were then carefully listened for by each disputant, as well as by some independent observers, after the thorax had been opened by an extensive medial incision without injury to the pericardium. The viens were then compressed, and all noted that the sound became gradually slightly diminished, but did not become inauble, the tone remaining distinct as long as the heart continued to beat. In the case of the dog, the same phenomenon was observed even after the heart was removed from the body, and the same was noted in the ventricle when removed below the valves. The authors therefore arrived at the conclusion that a definite and characteristic tone, similar in quality to the first sound, is produced by the heart-muscle, under circumstances that render it impossible for any tension of the valves to contribute to its production.—*The Lancet*, October 31, 1885.

Some Observations on the Theory of Bronchial Asthma, Viewed in the Light of the Pathology of Hay Fever.—Hay fever occurs in winter or spring; sometimes it occurs at sea, or in the heart of a great city; sometimes, when no pollen can be found in the air, it arises after a full meal, or in the middle of the night; sometimes it appears almost instantaneously under the influence of intense light, the heat of a great fire, the odors emanating from certain localities, plants, and animals; some particular place or position occupied in driving; or from emotions and vivid ideas. In an able and suggestive paper in the January number of *The American Journal of the Medical Sciences*, Sir Andrew Clark points out that in these and in all alike cases there are clearly two main factors at work, a certain local or constitutional predisposition and some immediately acting exciting cause. That some such predisposition exists is plainly proved from the fact that the exciting agents which produce the malady in one class of persons entirely fail to produce it in another; and that these exciting agents, in their relations to the persons acted upon by them,

are in a remarkable manner specialized seems also proved by the circumstances that the emanations from a stable which in one person provoke a severe attack, produce in another, liable to hay fever, no sensible effect. And of the persons subject to this disease, it must be said that they are not always affected in the same manner by the same agent; for sudden intense light which may bring on an attack at one time will quite fail at another; and so we are compelled to conclude that the organism, or some particular part of it, varies so much in its conditions that its relations to its environments are capable, without sensible structural alteration, of becoming completely changed.

When we inquire into the family and personal history of an individual subject to hay fever, we shall discover as the prominent point in it that the patient and his people are more or less "neurotic." There may be found among members of the patient's family the disease of which he is himself the subject, gout, such skin troubles as urticaria and eczema, migraine, neuralgia, epilepsy, and no inconsiderable sprinkling of pulmonary disease. But that which will be found the most widely, and will connect them all, will be a sensitive, an irritable, and an unstable nervous system.

In a series of propositions Sir Andrew sets forth what he regards as the teaching of a study of hay fever concerning the pathology of bronchial asthma, holding that it is a neuro-vascular trophic disease, and has its roots in a special vulnerability of the respiratory mucous membrane, of the respiratory nerve centres, and of certain portions of the sympathetic.

Intestinal Obstruction. — There seems to be great diversity of opinion in regard to the question of the treatment of intestinal obstruction. Some men advocate immediate operation, while others would resort to every other measure first. That we may have some distinguished authority to guide us in this grave situation, we note Mr. Jonathan Hutchinson's closing remarks in the *Med. Press*, October 7. He says:

"I advise that very early in all cases of obstruction the attempt at what I have called the abdominal taxis should be done patiently and thoroughly, and then I would wait a long time. I would use belladonna, laxatives, repeated abdominal taxis. I would avoid injury. I would do a lateral operation, and as a last resort I may be driven to open the abdomen in the middle line, and do the best I can. If it be possible to cut into the bowels, and so empty them, then I think laparotomy has been very much simplified."

It seems to us, after reviewing the subject, that if we can make any kind of an accurate diagnosis as to the locality of the obstruction, early operative interference is called for, before the possibly incarcerated gut has had time to become gangrenous.—*Med. and Surg. Reporter.*

A New Hypnotic.—A mixed acetone, known as phenyl-methyl acetone, the actions of which have been studied by Popof, of Warsaw, has been found by Dujardin-Beaumetz and Bardet, to possess valuable hypnotic properties. Within the body it is transformed into carbonic and benzoic acids, and is finally eliminated in the urine as hippurates. A dose of from 5 to 15 centigrammes, mixed with a little glycerine, and given in a gelatine capsule, causes in an adult a profound sleep. In alcoholic insomnia it seems to act better than chloral or paraldehyde, and in nine cases no ill effects were observed. The odor of the breath is rendered unpleasant by the elimination of acetone from the lungs. Injected beneath the skin of a guinea-pig it produces a remarkable torpor, which gradually deepens into coma, and the animal dies in five or six hours.

The name *hypnone* is suggested as a more suitable designation for this acetone.—*Med. News.*

Kolpohysterectomy for Cancer, with Tables Comparing its Methods and Results.—The recent announcement of but an 8 per cent. mortality in 24 consecutive cases by Fritsch, of but a 9 per cent. mortality in 55 con-

secutive cases by Martin, and of 16 cases by Staude, without one death, has revived a somewhat abated interest in this operation. Sänger's mortality of 28 per cent. obtained in 1883, had to the end of 1884 remained unaltered, notwithstanding the increased numbers of Mundé's, Doche's, and Duncan's list. The limits of success had been apparently reached, and the operation, even by its friends, abandoned to the opprobrium of an extraordinary death-rate, which has been in a degree lifted in an elaborate paper by Dr. S. E. Post, which appears in the January number of *The American Journal of the Medical Sciences*. The article ably presents a brief history of the operation, the fact of a recently diminished mortality, with an analysis of its concomitants, and among them possibly its cause. The author shows:

1. The results of kolpohysterectomy for cancer have progressively improved with increase of the number of operations.

2. The total number of operations done up to the present time is approximately 341, with a total mortality of 27 per cent. 222 cases were treated with the open peritoneal wound, with a mortality of 22 per cent. Of the 222, 93 had the supravaginal wound covered by peritoneum, with a mortality of 18 per cent.; and of the 93, 50 were operated upon during the past three years, with a mortality of 10 per cent.

3. Of 97 cases who survived the operations done previous to 1883, 18, or 20 per cent., are known to have been well at the end of eighteen months or two years.

4. The latest results of kolpohysterectomy for cancer contrast not unfavorably with those of the total extirpation of other organs for malignant disease.

5. The tendency of medical literature is to regard kolpohysterectomy for cancer as a legitimate operation, subject only to the restrictions common to other extirpations for malignant disease.

The best specicialty in medicine is common sense, founded on experience general practice.—*Med. Record.*

Miscellany.

The Separation of Materia Medica and Therapeutics.—Professor Horatio C Wood, of Philadelphia, writes to the *Medical Record:* "In your issue of November 21st is a letter from Dr. Mary Putnam-Jacobi, in which attention is called to the separation of the materia-medica course from that of thereapeutics in the Woman's Medical College of New York, and the assertion made that such separation 'is an entirely original one and entirely peculiar to our school.' The first impulse of gallantry was to leave Mrs. Jacobi and her self-congratulations undisturbed; but jutice seems to require the statement that in the University of Pennsylvania such separation was made as long ago as 1878, and has been fully carried out ever since. The first year the student is occupied by a course of laboratory instruction in practical pharmacy and in the study of pure materia medica, and he is required to pass an examination — including the putting up of a prescription—on each of these subjects before entering the second year. During the second and third years the physiological action of drugs and practical therapeutics receive the student's undivided attention.

Application to Allay Itching of the Mucous Membrane.—M. Bazin (quoted in "*Union Médicale*," December 10, 1885) remarks that the same applications will not answer for all the mucous membranes indiscriminately. For the ocular conjunctiva he advises a collyrium of 1 or 2 parts of copper sulphate to 5,000 of distilled water. For tingling of the tongue he recommends a gargle of from 10 to 30 parts of Lebeuf's "coal-tar saponiné" (a preparation of coal-tar and quillaya) to 300 of water. For itching within the nostrils, injections of a 1-to-1,000 solution of carbolic acid, with or without the addition of glycerin, are advised. For the mucous membrane of the vulva solutions of corrosive sublimate and of mercury nitrate are particularly efficacious. Glycerole of tar may also be used, or, better still, glycerole of tannin or of starch. —*N. Y. Med. Jl.*

Nutrient Suppositories.—*The British Medical Journal* says a case was related by Mr. Godlee, for himself and Dr. Barlow, at the last meeting of the Clinical Society, in which the advantage to be derived from nutrient suppositories was well exhibited. The patient, as will be seen from a perusal of our report of the meeting, suffered from typhlitis. Mr. Godlee opened the abscess-cavity, and allowed a large quantity of fœtid pus to escape. The patient eventually quite recovered, without any palpable evidence of the thick bands of inflammatory material which are so troublesome in many cases treated on expectant methods, and has since had no sign in any way of any trouble whatsoever about the cæcum. Dr. Barlow, speaking of the dieteic treatment after the operation, remarked "that in this case it was especially desirable to keep the stomach and intestinal tract at absolute rest. For many days, therefore, the very minimum of food, namely, a little barley-water, was given by the stomach, and the patient was fed by the rectum. The thirst was found to be entirely relieved by enemata of three-quarters of a pint of water, which were in all cases absorbed. With regard to rectal alimentation, it is often observed that after two or three days the rectum becomes intolerant of nutrient enemata. To avoid this result, food was given in the form of digestive suppositories. Of these, two very convenient forms were made by Mr. Gerrard, dispenser at University College Hospital. The first was made by diluting a good meat-extract with water, and peptonising it with Bullock's pepsin, neutralising, and then concentrating, to a soft paste. Cocao-butter was then added in fine shavings, and intimately mixed with one third of its weight of the peptonised meat-extract, and rolled into cones weighing 100 grains. The second was made by peptonising milk with pancreatic solution, boiling and concentrating to a paste, mixing and dividing as in the first case. Peptonised milk being now sold in a concentrated form, it may be used instead of ordinary milk, which saves much time and trouble. The suppositories were certainly absorbed, and kept the patient going for several days. One was introduced about every three hours. His tongue became very dry, and after a time he was given some pieces of underdone chop, which he was allowed to chew and to swallow the juice derived therefrom, but not the fibre. Besides maintaining his nutrition fairly, the patient, who was rather an irritable, querulous subject, was satisfied and comfortable, and the advantage in keeping his abdomen quite quiescent was very great indeed." If other cases should confirm the favorable impression as to the advantages to be derived from this method of feeding, when contrasted with the failure which in a fews days generally results from the attempt to sustain life by nutrient enemata, as the rectum generally soon becomes intolerant of them, there will doubtless be found a wide use for these suppositories in the very large class of cases in which the stomach requires to be kept at rest. Those who employ them may find, too, that the liquid which the system requires daily may be in some cases administered by the stomach; this would, one might suppose, tend still less to the disturbance of the lower bowel, and leave it still more at rest to digest and absorb the suppositories alone.

Primary Sarcoma of the Right Kidney.—Dr. Walter G. Smith, of Dublin, records in the January number of *The American Journal of the Medical Sciences* a case of this rare form of disease which posseses some features of marked interest. Little difficulty attended the diagnosis, as the shape bore out Sir W. Jenner's dictum, that a diseased kidney preserves it rounded form and never acquires a sharp edge. But the diagnosis of this condition is not always so easy, and swelling of the kidney is more often the subject of errors of diagnosis than of any other abdominal organ. The absence of intestine in front of the tumor, and the passage of numerous fibrinous clots without hæmaturia, were note worthy points in this case.

Owing to the fact that metastatic deposits are stated to have occurred in

seventeen out of forty-one cases collected by Dr. Windle, an operation was decided to be inadvisable. In the light of the post-mortem evidence this was to be regretted since at the autopsy it appeared that, considering the nature and attachments of the tumor, the chance of a successful result would not have been inconsiderable.

M. Pasteur's Treatment of Hydrophobia.—*The British Medical Journal* says, M. Gomot, the Minister of Agriculture, has officially visited the laboratory of M. Pasteur. He is so well satisfied with his visit that, it is announced, he will ask the Chambers to enable him to practise inoculation against rabies on a large scale, and to treat human beings suffering from that malady in a special hospital. About forty persons were under treatment when M. Gomot was at M. Pasteur's. One was a Hungarian, sent by his Government; another, a captain in the Russian Imperial Guard, whose hand a mastiff had bitten. He was accompanied by the Czar's medical attendant. There were several children who had received bites in the face. Two patients; whom M. Pasteur alleges that he has saved, gave him between them a donation of 48£ which he sent to a night asylum for indigent houseless persons.

Medical Men in Parliament.—The *Medical Times and Gazette* announces that the following named graduates in medicine have been elected to the new House of Commons: Charles Cameron, M. D., Glasgow; Robert Farquharson, M. D., F. R. C. P., West Aberdeenshire; Robert Bannatyne Finlay, M. D., Q. C., Inverness Burghs; Balthazar W. Foster, M. D., F. R. C. P., Cheshire; Henry Mitchell, F. R. C. S., Glasgow; Sir Guyer Hunter, M. D., F. R. C. P., K. C. M. G., Hackney; Sir J. J. Trevor Lawrence, Bart., M. R. C. S., Surrey; R. Macdonald, M. D., Ross and Cromarty; Kevin Izod O'Doherty, F. R. C. S. I., North Meath; L. J. N. Tanner, L. R. C. P., L. R. C. S., Mid-Cork; and Philip J. Vanderbyl, M. D., M. R. C. P., Potsmouth. Mr. Ernest Hart, Dr. Herbert Watney, Dr. Alfred Carpenter, Mr. Peter Royle, Dr. Danford Thomas, and apparently Dr. R. D. Lyons, have been defeated. Among the scientific men elected who are not medical graduates are Sir Henry Roscoe, the chemist, Sir Lyon Playfair, and Sir John Lubbock, who, as our contemporary remarks, "will form a scientific trio whom it would be difficult to match."—*N. Y. Med. Journ.*

American and British Laudanum.—The "Pharmacist" remarks that the tincture of opium of the new British Pharmacopœia is directed to contain about 0.75 per cent. of morphine, while the United States preparation contains about 1.4 per cent., if opium of mean standard strength is employed; and that therefore the influence in strength between the two laudanums is almost 100 per cent.—*N. Y. Med. Jl.*

Alopecia—Dujardin Beaumetz recommends:

℞. Chloral, - grammes 5
Distilled water, grammes 100

Apply to scalp at nigh. In two weeks great relief is produced.

In ordinary amenorrhœa, Professor Parvin recommends the following pill, which he learned from his teacher:

℞. Ferri sulph.,
Pulv. aloes,
Terebinthinæ, āā gr. j. M.

Gerhardt's Plumbum Causticum.—This consists of oxide of lead and potash. It is largely used in the Wurzburg Syphililtic Clinic to remove condylomata. It does not penetrate deeply, but produces a blackish slough. It is useful for warts on the glans penis. —*London Lancet.*

For Coryza.—The inhalation of the vapors from boiling water containing powdered camphor relieves all the distressing symptoms of coryza. About three drachms of camphor to a half pint of water will be of sufficient strength; and it should be employed for about fifteen minutes. Two or three sittings are said to effect a cure.—*N. Y. Med. Times.*

The Dangers of Nitrous Oxide Gas.—M. Gréhaut stated before the Société de Biologie that nitrous protoxyde does not act as an anæsthetic, but as an asphyxiating agent. Dentists happily describe its action by saying that their patients *vivent*, which means that they turn blue. M. Gréhaut belived that deaths from laughing gas were few, because it was only used for short operations, but it was an essentially dangerous anæthetising agent, and its use ought to be forbidden. M. Lafont has ascertained that accidents had resulted from its use. An infant died *in utero;* albuminuria returned in a cardiac patient; menstruation was arrested in another; epileptic fits which had ceased reappeared, and sugar reappeared in the urine of diabetic patients who had considerably improved in condition.—*Br. Med. Jl.*

The Treatment of Chilblains.—M. Meurisse ("*Journal des Sciences Médicales de Lille*," November 20, 1885; "*Lyon Médical*," December 6, 1885) advises the use of local baths of a mixture of sulphuric acid and water, in the proportion of a liqueur-glass of the acid to a quart of water. They should be used twice a day, ten minutes at a time. At first they cause a little tingling, then a sensation of warmth, and finally a feeling of comfort. The method is not contra-indicated by ulceration.—*N. Y. Med. Jl.*

Medical Items.

A Paris despatch announces that the four Newark children who have been inoculated by M. Pasteur, sailed for home January 3. M. Pasteur is of the opinion they will be protected from hydrophobia.

M. Debierre, of Lille, forwarded a note to the Paris Biological Society, stating that manganese has the effect of rendering the process of nutrition slower, and of encouraging the formation of blood-corpuscles.

A means of treatment for insomnia, which has been found useful by Dr. Von Gellhorn (*British Medical Journal*, November 7), is bandaging the legs with a bandage, of which a portion is wrung out in cold water, the dry part being applied over the wet. A dilatation of the cutaneous vessels is produced, which diminishes the cerebral circulation and induces sleep.

Twenty-one cases of dysentery in children, reported by Dr. G. Magruder, of Washington, were treated with fluid extract of ergot, five to twenty drops four or five times a day. Almost every case immediately responded to treatment, and was entirely relieved or much improved.

The *New York Medical Journal* says: "Spurious Vaccine, it is alleged, has been sold in this city, croton-oil having been used instead of genuine lymph to coat the quills, and many persons who suppose themselves protected from smallpox have simply been vaccinated with an irritant. It seems hardly possible that such a fraud could have been perpetrated and the offenders not brought to justice."

The *Louisville Medical News* and the *American Practitioner*, published by John P. Morton & Co., will be consolidated, and will in future appear as a bi-weekly publication under the name of *American Practitioner and News.* The Editors of the old Journals, Dr. H. A. Cottell and Dr. D. W. Yandell, will have charge of the coming Journals. The *News* and *The Practitioner* have hitherto been the representatives of the highest interests of medical Journalism and we feel assured the new Journal will come up to the highest scientific and professional standard.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, of the U. S. Army. From December 29, 1885, to January 4, 1886.

First Lieutenant, Thomas J. C. Maddox, Assistant Surgeon. Killed December 19, 1885, in affair with Apache Indians, near the White House, New Mexico.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service. For the week ended January 2, 1886.

Guitiras, John, Passed Assistant Surgeon. Upon expiration of leave of absence, to re-assume charge of the Service at Charleston, S. C., December 29, 1885.

Fattic, J. B., Assistant Surgeon. Appointed an Assistant Surgeon, December 28, 1885. Assigned to duty at Baltimore, Maryland, December 29, 1885.

Original Articles.

SOME OF THE COMPLICATIONS OF TYPHOID FEVER.*

BY JAS. B. WALKER, M.D., OF PHILADELPHIA.

Perhaps the novice in medicine, bearing the blushing honors of Commencement Day thick upon him, feels a greater confidence in his ability to wrestle manfully with typhoid fever than with any other of the multitude of diseases for whose mastery he has been endeavoring to equip. This confidence is, no doubt, born of the intimate knowledge of typhoid fever, and the regularity and simplicity of typical cases of the affection, as elucidated by theoretical lectures upon it, as well as by the classical descriptions of it in text-books of medicine. But his over-weening confidence is apt to experience some variation as his own experience ripens (?) (no, I dare not say *ripens*, for I doubt if one's experience is ever ripe with typhoid fever); let me rather say *widens*. A few cases, which will not tally in temperature chart with Wunderlich, assures him that typhoid fever is like most other diseases, great in its variety, and from a mild form of only a few days pyrexia, it grades to severe forms lasting as many weeks. His confidence, in manipulating it to his own behests, is apt to find early decadence in a practical experience, which usually does not require many years fruition; and as complications and sequelæ, new and diverse, present themselves with each succeeding year, he learns, at last, to look upon this disease as one of the most uncertain, in a prognostic sense, with which he has to cope; and to watch most sedulously even the simplest case for the earliest manifestation of evidences of aggravation or complication; and is not truly rid of all anxiety until the patient is not only well advanced towards, but has thoroughly entered upon convalescence.

An experience with a few of the rarer forms of complications, emboldened me to bring the subject before you in order that, peradventure, our conjoint experience may help to widen our knowledge, and make us better able to battle with a disease possessing such superabundance of duplicity.

Excessive temperature is one of the earliest complications. An evening temperature of above 104° F. if repeated, and especially if not followed by a decided morning remission, should be considered as an unnecessary pyrexia, demanding treatment. Antipyretic treatment should not be instituted for a less marked pyrexia occurring during the normal course of the disease, and the use of internal antipyretics for a lower temperature is very much to be deprecated. Simple spongings with cold water, or with tepid water, alone or medicated with some volatile substance, vinegar, alcohol, &c., may, of course, be used for even the mildest cases, being both cleanly and grateful; but the deprecation refers to the indiscriminate use of antipyretic doses of quinia, and other active agents, which have a prejudicial, as well as beneficial possibility. I will go a step further, and advise the use of such spongings even in the severer forms of recent occurrence, or where internal remedies are contraindicated, as in cases of irritable stomach, in which cases the volatile principle may govern us in the choice, or the direct use of ice bags or ice spongings may be resorted to, or the cold pack. Of the antipyretic remedies administered internally I have had extensive experience with but two, viz.: quinia and antipyrin. In private practice I have generally resorted to quinia in doses varying according to the urgency and severity of the pyrexia; and as this remedy is a local irritant and its administration by the mouth is, or may be, decidedly detrimental, and as its administration for tonic purposes in suppositories has proved desirable, I have been administering it in this manner for its antipyretic effect, with, at least, as much satisfaction as when administered by the mouth, and with much advantage to the stomach and intestinal wall. I order suppositories containing gr.x of this agent and gr.ss ext. opii, administering at night, night and morning, or night, morning

*Read before the Philadelphia Clinical Society, November 27. 1885.

and noon, as the case may be. In pyrexias of moderate severity, arising from transient causes, this agent is all that is needed, and proves very efficient, as more rapidly reducing the temperature to that compatible with safety than would spontaneously occur in such cases. But one early learns the utter non-utility of quinia in many cases of severe pyrexia, where such an agent is most sorely needed. I believe such cases are usually those in which owing to the virulence of the poison, either from quantity or quality, or the susceptibility of the patient, or from other equally occult cause, the febrile character of the affection is especially marked, whereas the intestinal and other symptomatic lesions may be quite mild. In such cases, marked by *high fever*, and but little else, I have usually found quinia "a delusion and a snare," even when administered in large doses by the mouth.

In the wards of the Philadelphia Hospital, where a large number of cases of typhoid fever is usually under observation, the new antipyretics have successively been given a trial with, so far as I am able to learn, decided preference for antipyrin. This new agent, a derivative of aniline, given in doses of gr.xx, repeated once, if necessary, will reduce the fever in the vast majority of cases, and that with more certainty than any other antipyretic with which I am familiar. In cases where the stomach is irritable it may be administered in solution by the rectum. Gr.xx by the mouth, and gr.xxx by the rectum, need not usually be repeated, and will, in the vast majority of cases, promptly reduce the temperature from 2° to 4°. In from 12 to 18 hours it will rise again, sometimes reaching in 24 hours a height equal to that from which it fell the day before, requiring another dose, to be repeated in some instances for two or three consecutive days. But as this repitition is without unpleasant result there is no objection to it, whereas the advantage gained by the lessened pyrexia, for even a few hours, is not to be despised. In the temperature chart, which I here show you of a case of typhoid fever, with relapse, the records show a reduction of temperature from 104° at 12 M. to 100.4° at 9 P. M. on the forty-second day of the disease and the fifth of the relapse, owing to the administration, per rectum, of gr.xxx of antipyrin. The following day gr.xxx, by enema, at 6 P. M., when temperature was 104°, was followed by reduction to 99.4° by midnight. Two days after temperature 104° at 9.30 P. M. caused it to fall by 12 P. M. to 100.2°. The effect is more certain and rapid than that of quinia, but I believe it is not so permanent; usually in 24 hours it again creeps up toward to the point whence it fell. This patient had his first normal or subnormal temperature on the twenty-eighth day of his attack, the temperature the evening before being 102.6°. The relapse began nine days later, evening temperature 101°; the following day evening temperature reached 104.6°. The highest temperature in the first attack was 104.6°, which it reached on the eleventh day and again on the twenty-third. The highest temperature of the relapse was 106.8°, which was reached the ninth day thereof. A temperature of below 105° and 105.5° was reached on the third, tenth, fourteenth and fifteenth, and below 105.5° and 106° on the eleventh and twelfth day of relapse. The first normal or subnormal temperature of relapse was reached on the fifthteenth day, temperature at 5 P. M. 97.6°, the temperature the night before reaching 105.4°, fifty-two days from the commencement of the disease, and for the previous three and subsequent four days the difference between the morning and evening temperature was four to five degrees.

This is the only case in which I have found it *necessary* to administer antipyrin in this way; although it may be *desirable* to so administer it, except when by profuse diarrhœa or other cause the use of the rectum, for such purposes, is contraindicated. The temperature records of the Philadelphia Hospital will verify this record repeatedly as to the promptness and efficiency of antipyrin, *as a rule.* Of course, exceptions occur, but these exceptions are like destructive conflagrations, which defy all efforts towards extinction, and which only prove the in-

ability of the antagonistic power to cope with them, but do not argue against the general utility of such power. So, in spite of two cases of excessive pyrexia in typhoid fever, occurring in the wards of one of my colleagues of the Philadelphia Hospital, in which antipyrin proved absolutely inert, I have no doubt of its superiority over quinia in this regard, nor of the appropriateness of its title of *antipyrin*.

I have used resorcin in but two instances, and inasmuch as it seemed to induce nausea and vomiting in one of these, I have not since resorted to it. In only one instance have I records of a similar effect with antipyrin, and that was in one of the two cases of excessive pyrexia above referred to, in which it proved ineffective, and in which it had been given in large and repeated doses.

Thromboses have long been recognized as amongst the serious, and when located in the heart, the most surely and rapidly fatal of the complications of typhoid fever. I have had two cases of femoral and one of iliac thrombosis as complications of the period of convalescence, and this after protracted illness.

Dr. N., who had an unusually protracted prodromic period of from four to six weeks, during which time he had thought himself suffering with malaria, and kept on with his work, visiting his patients, some of whom had typhoid fever, two or three of whom died. During this long period he had no appetite and ate but little. The day I first saw him he had visited several patients, and at that time, 7.30 P. M., his temperature was 104°, although he was sure he had not typhoid fever. He was put to bed and ran a fair course until convalescence, with occasional rather severe diarrhœa and some intestinal hemorrhage. One or two days after the fever had been normal in the morning, though the evening temperature still "ran up," his attendant, contrary to explicit directions, allowed him to sit up to stool; at my next visit he complained of a pain along the right femoral vein, from the groin downwards, which was tender to pressure and gave other evidence of phlebitis, resulting in an excessive phlegmasia dolens; but which subsided only to be followed by a thombosis of the left iliac and femoral veins, whose onset was accompanied by a shock so severe as to threaten to prove fatal for thirty six hours. The subsequent phlegmasia was not so excessive in the left as it had been in the right, and convalescence seemed again establishing when a recurrence of febrile symptoms with diarrhœa, but without tympanites or return of rose spots, proved too much for him. In this case the thombosis was attributed to a feeble heart combined with a hyperinosis, both consequent upon the prolonged period of fasting prior to the outbreak of the fever and the diarrhœa, hemorrhages and fever of the attack itself, and was apparently *directly* due to the position allowed the patient at stool, just prior to its occurrence.

The third case, that of Dr. S., occurred also after a protracted attack, in which the primary fever lasted for five weeks, and in which the patient, not a milk drinker, was fed largely on meat broths. This patient was badly nursed, and, no doubt, was allowed to dictate and order her ways and those of her nurse's even though counter to those of the physician in charge, although, of course, entirely without his knowledge, or his means of knowing, as events proved, necessitating the dismissal of the nurse and the employment of one skilful and obedient, whose arrival was immediately followed by a marked change for the better, and a response to remedial measures which before had been woefully absent, no doubt due to their non-administration. In both these cases I believe the result was largely due to the fact that the patient, being a physician, was allowed by the attendant to tamper, at pleasure, with the orders of the attendant and responsible physician. The moral of which is, under all circumstances in typhoid fever, have a nurse on whom you can rely to carry out your orders unmitigated, and especially if the patient is a doctor of medicine. This patient, though presenting a decided femoral phlebitis, with its cord-like character, pain and tenderness, did not have a severe phlegmasia. The

thigh swelled, perhaps, to twice its circumference, but the leg was less swollen and the foot still less. It responded nicely to treatment, although the tenderness and rigidity of the femoral vein lasted for some time and rekindled twice, but was promptly met and controlled. The treatment consisted in the use of *position*, the patient recumbent with limb raised, that gravity might assist the blood to leave it; *warmth*, insured by large hot mush or potato poultices during the cold stage, followed by a cotton or flannel jacket, until the pain subsided, and the use of a bandage, from the toes, on the patient leaving the bed during convalescence, if there was any tendency to swelling or return of pain. Besides this, an ointment of belladonna, or belladonna and mercury, or of mercury alone, was used at first, and during the acutely painful stage, followed by iodine applications, which were kept up at intervals until all swelling and hardness had disappeared. Dr. Hutchinson (Pepper's System of Medicine) recommends hot cloths saturated with hot vinegar and water. Internally, ammonia was given freely in the form of the carbonate and aromatic spirits, both for the effect on the heart and against the shock, as well as with the theoretic idea of increasing the alkalinity of the blood and lessing the dangers of a clot. Absolute quiet was, of course, enforced, lest thrombosis, cardiac or other, might result, or that a portion of the clot, already formed, might be broken off by the movements of the affected limb and distant embolism result. Although the records of thrombosis in typhoid fever make of it not a severe lesion, only two of thirty-one cases collected by Liebermeister, and three of seventeen collected by Murchison having proved fatal, and all of Hutchinson's cases (number not mentioned) have ended in recovery; yet it seems to me that we must look upon this complication as the representation of a very serious and critical state of the circulating fluid, and one in which extremest care must even be taken to ward off, if possible, serious, if not fatal, consequences.

Pneumonia, either croupal or catarrhal has fallen under my observation a number of times. The most markedly severe as well as successful case, was that of R. C., about 20 years of age, unmarried. In convalescence a bronchial catarrh, which had existed throughout a decidedly severe attack of typhoid fever, involved the lobules of the lungs, especially the right, in a quite extensive, though diffuse secondary inflammation. Drs. William Pepper, Hanna T. Croasdale and Amy S. Barton united with the author in this diagnosis, and a very grave prognosis, considering all the elements of the case, was the result of our deliberation. The patient, however, survived, his lungs cleared up entirely and has since successfully passed rigid examinations in old Life Insurance Companies. In this case turpentine, gtt. xv.—xx of the oil every 3 or 4 hours was the especial stimulant resorted to. This has long been my favorite pulmonary stimulant in typhoid fever. The reason for its choice was, I admit, pure theory. If the delirium, typhoid state, hebetude of typhoid fever be due, as claimed by Murchison, to the presence of the results of heterogenous waste in the blood, I argue why add to this heterogenous waste by administering ammonia in any form. I may say that in the above, as in many other cases of typhoid fever with catarrhal complications of the lungs, the result of a resort to turpentine, as a substitute for carbonate of ammonia, has proven its usefulness. But when at the present day carbonate of ammonia is vaunted as of specific virtue in typhoid fever, Simon pure, or complicated, my theory may prove mythical, although the results of my experience with turpentine remain the same. In, however, the croupous variety the case is different. Here from the inception of the crepitant râle to the disappearance of all evidence of solidification I believe carbonate of ammonia to be our sheet anchor, whether the explanation of its benefit rests on its prevention of solidification of the exudate, as claimed by Bartholow, or on its influence on the heart, the vaso-motors and the respiratory centres, or on all combined. In doses of grsv.-vij. in syrup or mucilage of acacia, well diluted, to rob it of its

acridity to throat and stomach and repeated 2 or 3 hours, it furnishes with whiskey, good food and jacket poultices, an aid which is worthy of great confidence and praise.

The onset of croupous pneumonia is sometimes so insidious, that its approach should be sedulously anticipated in cases of decided severity. It will not do to expect marked changes in the course of the disease by its occurrence, as the temperature chart, which I now show you, will testify. The onset of croupous pneumonia, as a primary disease, is marked by most decided symptoms which are usually pathognomonic. But in its stealthy approach as a secondary phenomenon, it is sometimes not suspected until well advanced. The respiratory difficulty, combined, or not, with more or less marked cyanosis, due to circulatory disturbance, is more suggestive than any rise of temperature and should suggest the examination of the lung which the position of the patient has placed lowest and most inaccessible, as well as that which can be examined without disturbing him. In this form carbonate of ammonia is the remedy of remedies. It should be given in full doses, repeated at least every 2 hours. Alcoholic stimulants are usually so required.

Convulsions, epleptiform in character, may occur in typhoid fever. Dr. J. C. Wilson, in his work on "The Continued Fevers," refers to them as follows under the head of symptoms referable to the nervous system: "*General Convulsions* are rare. They occur with greater frequency in children than in adults. It would appear that, although occasionally associated with albuminous urine, they also occur independently of that condition, but are, in all instances, of the greatest prognostic import."

Jas. M. Hutchinson, in his article on typhoid fever in "Pepper's System of Medicine," says: "General Convulsions are not common, but occasionally do occur. Although a very grave symptom they are not invariable fatal. Recovery took place in one of two cases which came under my own observation, and in four of the six recorded by Murchison. They are not always associated with an albuminous condition of the urine. In neither of my cases was there albuminuria and in only one of the four of Murchison's cases in which the urine was examined was it present. In one of my cases, the fatal one, the convulsions seemed to have been induced by giving the patient improper food; in the other no cause could discovered."

These authors both refer to this symptom under the head of the clinical history of the disease. With such convulsions I have had no experience. As a sequel, however, I have observed them on two occasions.

Case I. G. A., aged 22 years, traveling salesman, taken sick with chilliness and fever while "on the road." Returning to Philadelphia, I found him, October 2d, 1883, in bed with a history of several days illness. Temperature 103.5° F., severe headache and with rose spots already on the abdomen. The subsequent course of the attack was marked by a more than ordinary exacerbation of temperature; repeated attack of epistaxis the first few days; three quite profuse intestinal hemorrhages during the third and fourth weeks; one attack of pulmonary œdema on the twenty-second day in bed, with associated symptoms of profound collapse and threatened imminent dissolution for several hours; delirium and continuous irrationality for upward of four weeks. On morning of the thirtieth day in bed, when the temperature was sub-normal 97° F., and after the morning temperature had been between 98° and 99° for two days, and immediately following the first normal evening temperature, without appreciable provocation he was seized with an epileptiform convulsion, which was general, lasted for several minutes and was followed by stupor. There was no subsequent pyrexia. There had been no thrombosis anywhere, nor was there any albuminuria at the time, nor subsequently; the weak heart and profound anæmia, from a prolonged and severe attack, alone suggested a cause. Professor Pepper saw the case in consultation and agreed in the causal diagnosis, which seemed to be verified by the sub-

sequent history. Increased stimulation for a few days, with the use of sodium brom. for twenty-four hours, was followed by uninterrupted improvement to complete convalescence. The patient has had no convulsions or other nervous phenomena since his recovery, nor had he ever a convulsion in his childhood. I consider it a case of post-febrile convulsion due to cerebral anæmia.

Case II. Dr. E. W. S., woman, age about 25, was taken with typhoid fever, July 28th, 1885. The initial symptoms were markedly cerebral, following a walk in the sun on a very hot day, inducing Dr. James Mitchell, who was called to the case in my absence from the city, to attribute the disease to heat-stroke, for the first few days. The fact that in a family with whom she had stopped for two days, ten days previously in a neighboring city, three cases of typhoid fever developed at the same time; together with the subsequent clinical history of the case, under observation, which ran a typical course (though protracted) left no doubt in our minds of the true nature of the ailment. The cerebral symptoms of the first few days subsided and, except for occasional delirium, no nervous symptoms afterward developed until convalescence. During the attack this patient had phlegmasia dolens, due to femoral thrombosis and is one of those already referred to. About the tenth week, when the patient had been sitting up for some days gradually gaining strength, after semi-reclining at a front window for two hours, and while the nurse was absent from the room, she proposed to her brother a walk back to her office, in the back of the same story, with a half flight of steps to descend in order to reach it. This was her first visit so far from her room, and this after her brain had been rolled by gravity by her position for the past two hours. On reaching her office she asked for a drink of water as she felt faint, and sinking into a chair fell into a convulsion epileptiform in character and quite decided, lasting some minutes and terminating into a stupor. Her tongue was bitten during the attack. She was at once returned to bed, restoratives were administered and she again improved, but several small and some severe attacks of a similar nature followed. Sometimes two or three attacks, wherein she simply lost consciousness and twitched but slightly, would occur in a single day. She would complain of a feeling of impending death from cardiac distress in the period immediately anticipating the attack, corresponding in time and duration to the epileptiform aura. Persistent use of small doses of sodium brom. (about 45 gr. daily) with tonics and stimulants have carried the patient beyond, not only these recurrences, but also, I believe the danger of their return. This patient had never previously, even in infancy, had a convulsion of any sort. The first was attributed to the cerebral anæmia, sufficient cause for which existed and most of the subsequent ones were due, apparently, to an easily formed habit in an excitable and debilitated nervous temperament.

Impairment of Intellect sometimes exists as a sequel of typhoid fever and has been at times a matter of serious moment in a prognostic sense. It is most apt to occur in cases with well marked nervous phenomena during the course of the disease. As the other symptoms subside, temperature, pulse and respiration becoming normal, the tongue cleans, appetite returns, but days, even weeks, pass with imperfect cerebration persisting. Lucidity may sometimes appear momentarily, only to verge into mental darkness. Mania active, simulating the delirium tremens from alcohol, may occur, as in a case which I recently saw in consultation. Such cases may suggest the possible existence of a more or less permanent lesion which would leave persistent traces in the subsequent intellectual life. But against this prognosis stands the records which show the ultimate recovery almost invariably, of full mental rigor, though it may require weeks or even months to bring the consummation. No wonder the cerebral functions are impaired, with every tissue in the body suffering from prolonged supply of impoverished and poisoned blood. With the rejuvenation

of the sources of blood supply and the avenues of blood purification, the current will become less and less corrupt, and more and more nutritious and healthy tissues will result, cerebral and glandular, as well as muscular. In such cases strychnia and ansenic for their influence on cell nutrition, aid materially in fowarding the desired result, and should not be overlooked in the employment of iron, simple bitters and the other grosser tonics which, of course, have their service as well. Other exaggerated symptoms, complications and sequelæ have, of course fallen under my notice, and might justly claim attention in this paper but as it makes no pretention to exhaustiveness and as it has already grown beyond what was at first intended I will tax your time and patience no further.

THE ADMINISTRATION OF THE HYPOPHOSPHITES IN POWDER.

BY ETHELBERT CARROLL MORGAN, A.B., M.D., OF WASHINGTON, D. C.

Fellow of the American Laryngological Association, etc., etc.

Practitioners frequently encourter patients in whom the ordinary saccharine preparations of the hypophosphites cause serious gastric disturbance, loss of appe tite and interference with nutrition. Individuals suffering from diseases in which hypophosphites are indicated often possess an intolerant digestive apparatus, thus rendering the administration of syrups questionable and occasionally impossible. The writer has for these reasons, long been accustomed to prescribe sodium, potassium, calcium, iron, and other hypophosphites, in the form of powder, taken dry or stirred in wine, whiskey, brandy, milk or water. Some of my professional colleagues have doubtless employed these salts in powder and it is for the purpose of directing more general attention to the subject that I write this article.

The therapeutic advantages resulting from the combination of pepsin and various salts of the hypophosphites are apparent, my attention being first called to the fact by Mr. J. S. Tyree, of our city.

The formula can be varied to meet special indications; but a most serviceable combination is as follows:

PULV. HYPOPHOSPHITUM CUM PEPSINO, (MORGAN.)

℞.	Calcii Hypophosphitis,	5	parts.
	Sodii, " "	5	"
	Ferri, " "	2	"
	Mangani, " "	1	"
	Pepsini (Boudault's Neutral	8	"
M.	Sacchari Lactis	4	"

This powder should be finely ground and kept, as well as dispensed, in glass. It can be prescribed in bulk, one half teaspoonful representing about fifteen grains, the adult dose. The preparation is to be taken three times daily, after eating, and preferably in milk.

Lactopeptine, ingluvin, or scale pepsin, may of course be substituted for the neutral pepsin of Boudault, which latter after repeated trials I prefer.

Mr. Henry E. Barrett, the accomplished pharmacist, has aided me materially in perfecting the above described combination, which can often be readily tolerated by persons unable to use any other preparation of the hypophosphites.

It is a matter of serious regret that the commercial salts of the hypophosphites are subjected to adulterations and great discrimination must be exercised to obtain a chemically pure drug.

The oldest medical college in the United States is now known as the Medical Department of the University of Pennsylvania. It was founded by Dr. John Morgan and William Chappen in 1765. The second medical college was the College of Physicians and Surgeons, of New York, formerly a medical school established under the name of King's College, founded in 1767. The third oldest medical college was the Harvard Medical School, founded in 1782 by Dr. John Warren. The first medical college in the West was the Medical Department of Transylvania University, of Lexington, founded in 1799; Dr. Samuel Brown being its first professor.

Society Reports.

PHILADELPHIA CLINICAL SOCIETY.

STATED MEETING HELD NOV. 27, 1885.

The Vice-President, Dr. JOHN B. ROBERTS, in the chair.

Dr. James B. Walker read a paper entitled,

SOME OF THE COMPLICATIONS OF TYPHOID FEVER.*

DISCUSSION.

In the discussion, which followed the reading of the paper,

Dr. Edward T. Bruen said the fever was an incident or feature of the general process of enteric fever. Since we cannot limit the course of the disease it is well not to treat the symptom of rise of temperature, even when as high as 104° or 105° F., unless mischievous brain symptoms arise or other direct evidence that the elevation of temperature, is decidedly unfavorable to the comfort of the patient. The cold water treatment is the most efficient antipyretic agent, but it may induce such exhaustion of the patient that it does more harm than good. In August he supervised the treatment of sixteen cases of typhoid fever, many of them in the University Hospital, and in five of these cold water was used to reduce temperature, but in only two of them was it followed by good results, in others the treatment produced decided discomfort. He does not habitually employ *antipyrin* as an antipyretic, because he does not habitually aim at reduction of temperature. But his experience with antipyrin went to show that this agent will reduce temperature more quickly than quinia, and without unpleasant consequences. The drug is particularly useful when the temperature lingers above normal in the closing stages of enteric fever or at the close of a relapse. The reduction of temperature may continue several days after the use of antipyrin. The dose employed was *ten* grains every hour, in compressed pill, sometimes *forty* grains. Antipyrin can, however, be given in solution, but has an unpleasant taste.

In reference to *phlebitis*, he objects to the use of mercurial ointment, because it is difficult to remove it without causing much suffering to the patient and because constitutional symptoms may follow, especially under certain plans of internal treatment which may be carried on conjointly. Blistering is a painful mode of treatment, and the good effects are not marked. The use of hot applications, especially vinegar or laudanum, and hot water, and sometimes hot lead water are very soothing and useful.

In the *prognosis* of typhoid, the state of the *heart* is a most reliable guide, and he believes in an early supporting treatment. Perhaps all will admit that the early use of alcohol is very seviceable, but at all events the diet if limited may be very nourishing. Beef tea he seldom uses, unless as a laxative, but if milk is badly digested there can be no objection to the use of custards, plain rice pudding, milk toast. In this way the strength of the patient is is preserved though of course, the amount of food given must be within the reach of the powers of digestion.

Dr. Edward R. Stone said that he had had good results from quinia, per rectum. He had seen one case of convulsions in typhoid fever; but it was rather the convulsions of childhood in the disease, in a child, æt. 8 years, who had an unstable nervous system.

He had seen one case of prolonged cerebral inaction in a boy of 14 years, after a long and protracted course of typhoid fever. It was a long time before he could read, but after two or three months his physical condition improved and with it his mental condition. He thinks that patients are rather *over fed* than *under fed*. It is necessary to lay down directions in regard to the amount and *time* of feeding.

Dr. L. Brewer Hall said that he had sometimes found small thromboses in the veins of the eye and hemorrhage

*See page 217.

into the retina, after typhoid fever; and he questioned if there might not be the same condition in the vessels at the cerebrum, in these cases of cerebral inactivity?

Dr. Henry Beates said that he was especially desirous of giving emphasis to a point, made by the author of the paper in regard to the administration of quinia, and that is its use per rectum, whereby its local irritant effects are afforded and the undoubted serious mischief almost necessarily following its administration by the mouth are also avoided. In reference to the successful and unsuccessful use of antipyrin, in a very limited experience, he has been forcibly impressed with two clinical facts, which before being stated, will be premised by the teaching of Professor H. C. Wood regarding fever. 1*st. Pyrexia is due to* heat production being normal and heat elimination sub-normal; 2*nd.* heat production being *above* normal, and its elimination normal; now take two instances of high pyrexial typhoid, they each, for three or four consecutive evenings, possess a temperature of 104.5°, but the one does not emaciate as the other, neither does he, notwithstanding that the temperatures are identical, evince that serious inroad of his vital process indicative of approaching dissolution; indeed were it not for the thermometric observation we should be ignorant of the high degree of pyrexia. He believes that these two pictures indicate the proper use of antipyrin. Where the temperature is high and emaciation not correspondingly marked, antipyrin will successfully, temporarily, reduce it; but where pyrexia is high and emaciation is great it is valueless. The *one* fever point is maintained, principally, by *nervous phenomena*, the *other* by *active tissue change.*

Dr. John B. Roberts said that he had seen ulceration of the cornea and of the cellular tissue as a result of typhoid fever.

Dr. Walker, in closing the discussion, said he believed in *free* feeding in typhoid fever, but not in *over* feeding.

In a case running a mild course, without severe intestinal symptoms, he permits the use of soft boiled, or poached eggs, or egg custard with milk-toast, at times to vary the monotony of the milk diet; but when the milk agrees he considers it a sufficient and superior diet for any case, in from 3 to 4 pints daily. As for the prognostic significance of complications, no doubt they add to the gravity of the case whenever occurring, and require greater care on the part of physician and attendant than an uncomplicated case, but the *exact* influence in increasing percentage of deaths, was not known to him. As regards the idea thrown out by Dr. Hall, that on account of extravasations and ecchymoses in the retina, after typhoid fever, that it might be inferred that similar changes exist in the cerebral tissue inducing the mental hebetude etc., he would simply say that, inasmuch as the eye changes induced more or less permanent defect in many cases, and whereas the mental hebetude was almost invariably without permanency and cerebration was thoroughly reëstablished, he thought that we have sufficient indication that cerebral extravasations and ecchymoses were extremely uncommon as a cause of imperfect cerebration.

Dr. Clara Marshall presented

SPECIMENS OF BLOOD-CASTS FROM THE URETER.

September 25th, 1885, she was called to a patient, æt. 80 years, widow, Irish, occupation that of a store-keeper, who complained of pain in the left lumbar and inguinal regions, with passage of bloody urine.

Diagnosis, hæmaturia due to renal congestion.

The *treatment* consisted in the administration of the follow:

℞. Acid. gallic, ʒ ss.
Ext. ergot. fld. ʒ ss.
Infus. gent. co. ʒ iij.
M. Sig. teaspoonful every three or four hours.

Under this medication the amount of blood in urine diminished.

A few days subsequent to her first visit, Dr. Marshall was sent for in great haste, the patient stating that she had

passed, with considerable pain and tenesmus, a dozen or more of what *she* called "worms." From their length (being that of the ureters) and size, it was decided that they must be blood-clots from the ureter. Through the kindness of Dr. James B. Walker, who saw the specimens, the following report was obtained from Professor Joseph Leidy.

1302 Filbert Street, Oct. 7, 1885.

Dear Dr. Walker. — Your note was duly received. I thought it worth while to say that it is not remarkable that the old lady imagined she saw the lumbricoid clots move. When I first examined the one I retained for the purpose I thought it was a macerated earth worm, in which I could distinctly see the characteristic upper lip, the circular annuli and other less visible points. I actually slit up a portion of it and thought I was cutting through the skin of a worm; but on placing whole sections beneath the miscroscope they showed nothing but a homogeneous clot with the characteristic corpuscles.

Respectfully,

Joseph Leidy.

In addition to ergot and gallic acid, acetate of potassium, in gr xv. doses every three hours, was now given with the hope of preventing further formation of blood-clots, and under this treatment the hæmaturia disappeared. At this juncture the urine revealed, upon microscopical examination, the presence of epithelial and pus cells (probably vaginal), a few granular casts, and, in addition, the urine contained a large amount of inorganic matter, chiefly urates and phosphates. Judging by the seat of pain, the blood probably came from the left kidney. As to causation, there was no proof of the presence of calculi, or of acute imflammation; nor was there any certain evidence of malignant disease, the patient, considering her age being very well nourished. The diagnosis of passive hemorrhage, brought on by over-exertion and cold, seems most probable.

After the above report Dr. Edward T. Bruen related the history of a lady who had suffered from

VICARIOUS HÆMATURIA NEAR THE PERIOD OF THE MENOPAUSE.

The hæmaturia was attended with the passage of casts of blood from the ureters, and the symptoms continued for several years. The case suggested that vaso-motor vascular disturbance might at any period of life occasion hæmaturia.

He also commented on the obscurity of the diagnosis of malignant disease of the kidney by physical signs. The diagnosis must usually be inferential, from general symptoms. He instanced two cases of malignant disease of the kidney in which an absolute diagnosis was only made at the autopsy, although a provisional diagnosis of malignant disease was entertained.

SPECIMEN OF AN AMPUTATED LIMB.

Dr. Susan P. Stackhouse then presented a specimen for Dr. W. W. Keen with the following history: L. B., æt. 30 years. Mother died of consumption, father shows evidence of scofulous diathesis. In 1866 while at play in "*Clay Mill*" fell under a large revolving stone used for crushing clay; stone ran on right leg, tearing muscles of calf along a line longitudinally on inner border of muscles of calf, tearing said muscles backward toward out-side, presenting the posterior suface of the tibia. The attending physician stitched the parts to their places, but sloughing followed and they were removed to the bone for an area the full length and breadth of a hand. This wound healed by granulation in eight months. Four months subsequently an ulcer appeared on the spine of the tibia about the middle third, which was about the size of a silver dollar, smaller or larger at intervals, resisting all efforts to heal it. This remained for 14 or 15 years when it began to spread and became offensive, assuming somewhat of a fungous character. He continued to work, however, until 2 years since, when the disease had reached its present dimensions. I first saw the case about November 1st, and though he was losing strength rapidly, being unable to

move from his bed (while six weeks previously he was going out of doors) I advised amputation, as giving a possible chance to prolong life; while without it his time must be of necessity very short. It was, without exception, at this time the most horribly offensive thing I had ever seen in 20 years of practice, it being next to impossible for the family to remain in the house with him.

I did the operation on November 6th, assisted by Drs. Whitaker and Wheaton; he rallied nicely. The following clinical record may show his condition better than words.

November 7, morning, temperature 100.3°, pulse 108; evening, temperature 99.4°, pulse 104.

8th, morning, temperature 99.4°, pulse 98; evening, temperature 99.7,° pulse 98.

9th, morning, temperature 99°, pulse 98; evening, temperature 101.5°, pulse 100.

10th, morning, temperature 97.1°, pulse 100; evening, temperature 99.1°, pulse 100.

Gave a laxative and ordered quin. sulph. gr. ij. every four hours. Dressed and removed drainage tube.

11th, morning, temperature 99.4°, pulse 100; evening, temperature 98.4°, pulse 100.

A continuation would simply be a repetition; at no time after that did the temperature reach more than 98.5°, and the pulse gradually increased in strength and volume, while it lost in rapidity. Morph. sulph. was used as required. The dressing was 1 to 1500 bichloride mercury solution. Comparatively little suppuration. At this writing, November 27th, 17 days after the amputation, I consider him practically well. On the sixteenth day he was sitting up in an easy chair to rest. He looks and feels better than before, and I only regret not having a photograph of him before the operation, the improvement is so great. I am confident strangers cannot realize it without such aid.

Dr. John B. Roberts next reported

TWO UNUSUAL FRACTURES OF THE RADIUS.

The first was a "Longitudinal Fracture of the Base of the Radius" as follows:

"In August 1883, a man, æt. 25 years, fell from a window and was admitted to the Surgical ward of St. Mary's Hospital. I saw him the day after admission, when there existed synovitis of the right wrist. The lower end of the ulna seemed abnormally movable, and in manipulation I could feel a distinct slip and a crepitant snap. Passive motion of fingers gave pain at wrist. There was no deformity; and no fracture of the shaft of either radius or ulna detectable, though carefully sought. These mechanical symptoms were such as to make me believe that there was a more or less longitudinal fracture of the base of the radio-ulnar ligaments entering the joint. The synovitis was more general than I thought would have occurred if the ulna had been split, because then the small synovial sac above the triangular ligament only would have been involved. The common transverse fracture of the lower end of the radius was certainly not the lesion in this case. I carefully excluded its existence. The synovitis rapidly improved and after the lapse of a week the patient was discharged, at his own request, wearing the splint. I know nothing of his future history. He was probably treated at the hospital dispensary, but no acurate notes are kept of that service."

LONGITUDINAL FRACTURE OF THE HEAD OF THE RADIUS.

"A few weeks ago a woman, æt. 50 years, sustained a fall by which she injured her left elbow. Finding nothing sufficiently definite as to the character of the injury, I etherized her. The arm was swollen from the injury which had happened one or two days before; and the doctor, who had seen her soon after the accident, reported it as a case of fracture at or near the neck of the radius. A number of medical friends, and my Polyclinic class, examined the case carefully, but for a long time we were unable to make out the exact lesion. There was crepitus near the elbow, but it was difficult to locate it. At one time it would be said that the head of the radius was stationary during these

manipulations. Finally, I found that I got motion and distinct crepitus when I placed my two thumbs side by side on the head of the radius and made alternating pressure with them. This, to my mind, made it clear that there was a longitudinal fracture through the head and neck of the radius and that the uncertainty as to the rotation of the head of the bone, during pronation and supination of the hand, was due to the fact that the examiner's fingers was placed, sometimes, on the detached portion of the head, sometimes, on the part still connected with the shaft. No other fracture was found. The arm was put on a splint, merely to keep the parts at rest, for there seemed to be no tendency to displacement; and the woman was told to return the next day. Unfortunately she never returned to enable me to follow the history of the case."

MARY WILLITS, M. D.,
Reporting Secretary.

PREVENTION OF LACERATION OF THE PERINÆUM IN PRIMIPARÆ.—David P. Gaussen, M.D., M.R.C.S., Dunmurry, Co., Antrim, says in the *British Medical Journal:* I wish to state what I consider to be an important practical point in the manipulative treatment necessary for the prevention of laceration of the perinæum in primiparæ, or, at least, for its reduction to the smallest possible limits.

In a great number of cases, where the pelvis is of normal size, the dilatation of the perinæum is performed by the whole vertex of the fœtal cranium, and not by the occiput. In consequence of this, there is a great tendency for the movement of extension to take place before the occiput has properly escaped from behind the pubes; and, when this occurs, it naturally follows that the first the occipito-frontal, and then the occipito-mental diameters, which are much the longest diameters of the fœtal skull, will have to pass through the ostium vaginæ. Hence, in primiparæ, the result is often that more or less laceration follows the tremendous tension put upon the not previously dilated parts.

The treatment which I would recommend to be followed is to complete the movement of flexion by every means in our power, so that the movement of extension will not begin till the occiput has completely descended from behind the pubes. By this means, the shortest fœtal diameter compatible with the complete birth of the head has only to pass the ostium vaginæ.

I have found the following method to be the most useful. As the fœtal head, with each successive pain, gradually dilates the perinæum and the ostium vaginæ, the fore and middle fingers of the right hand should be passed up behind the pubes during a pain, as high as possible; and, having grasped the occiput, if possible, being inserted in some suture, should be retained there till the pain subsides, and as the head recedes in consequence, the movement of flexion is greatly aided. Then, during the few pains which immediately precede the birth of the head, the occiput should be grasped in the hollow of the right hand, and pulled down from behind the pubes, while the frontal part of the vertex should be pushed in an upward and backward direction towards the sacrum with the thumb of the same hand. This being accomplished, flexion is complete, and the termination of the case may be left to nature. With the above I combine lubrication of the parts and the prolongation of the second stage, as far as the limits of safety to the mother and child will will permit.

I do not claim complete originality for this form of treatment; but I think that, if known, it has not been properly appreciated, if we may judge from its absence from text-books on midwifery.

M. Laborde, at a recent meeting of the Société d'Anthropologie, exhibited some arrows which had been poisoned with curare a hundred years ago. He had wounded a few guinea-pigs with them, and the results were as powerful and as deadly as though the poison had been fresh.

The Medical Analectic, a monthly journal published by G. P. Putnams' Sons, will hereafter be edited by Dr. R. W. Amidon.

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BALTIMORE, JANUARY 16, 1886.

Editorial.

AN INDISCREET PHYSICIAN.—The British medical press has taken occasion to comment in quite plain and forcible language upon the action of Dr. Heywood Smith, a well-known and distinguished London physician, in regard to the girl Eliza Armstrong.

It will be remembered that some weeks back the *Pall Mall Gazette*, a noted London daily paper, created an enormous sensation by publishing numerous statements reflecting upon the depraved state of English society. A Mr. Stead, the special detective and employee of the *Gazette*, enveigled Dr. Smith into his schemes, and succeeded in inducing him to examine the girl Eliza Armstrong under chloroform, and to certify to the fact that she was "pure." This act of Dr. Smith was unwise and imprudent, and has brought upon him very severe censure and condemnation. The British Gynæcological Society, of which he was a prominent member and its efficient secretary, requested his resignation after expressing their thanks for distinguished services he had rendered to this Society, and affirming "their belief that in what he did in reference to the Armstrong case he was actuated by what he believed to be the highest motives, while committing a grave professional error."

The Royal College of Physicians, after carefully considering Dr. Smith's explanations and his apology, and acquitting him of deliberate intent to do evil, expressed the opinion that he has committed a grievous error which has brought discredit upon himself and the profession to which he belongs. The College regards his conduct as deserving the severest censure, and requests the President to express the views of the College, and to reprimand him accordingly. The President has addressed to Dr. Heywood Smith a severe reprimand, and warned him to be careful as to his conduct in the future.

The moral to be inculcated by Dr. Heywood Smith's misfortune is that the physician should ever be on his guard in lending his professional services to doubtful schemes and designs. There seems to be no doubt of the fact that his professional skill was levied on to foster an unjustifiable purpose, and, whilst Dr. Smith's motives may have been thoroughly good, his actions were injurious to the honor of his profession. The text of the reprimand addressed to Dr. Smith by Sir Henry Pitman, the President of the College of Physicians, seems to us to present a thoroughly correct and healthful statement of certain moral and ethical questions which frequently arise in the discharge of professional duties. The views of Sir Henry Pitman meet with our own conscientious endorsement, and are of such importance that we feel warranted in giving them a place in our columns. The reprimand reads as follows:

"The College has most carefully considered your conduct with reference to the girl Eliza Armstrong, your written explanation of your actions and motives, and your written answers to the questions asked by President and censors. Speaking generally, and without regard to this special case, or to cases involving medico-legal questions before, or about to come before, Courts of Law, it is, in the opinion of the College, a grave professional and moral offence for any physician to examine physically a young girl, even at the request of a parent, without having first satisfied himself that some decided medical good is likely to accrue to the patient from the examination, and also without having first ex-

plained to the parent or legal guardian of the girl the inadvisability of such examinations in general, and the special objections that exist to their being made. Moreover, the College feels that a young girl should on no consideration be examined excepting in the presence of a matron of mature age, and, so far as the physician can know, of good moral character. The College, therefore, condemns your conduct—(1) In examining girls of tender age, without the consent of their parents or legal guardians. (2) In making such examination without there being the least grounds for anticipating any medical benefit to the children to follow from your examination. (3) In examining these children in the sole presence of women whom you believed were till not long before prostitutes or procuresses. As to your having examined the child, Eliza Armstrong, as described by you in the evidence before the Court of Law, for the purpose of clearing the character of one who had, well knowing the consequences, voluntarily placed himself in an equivocal position in relation to the child, the College has a difficulty in conceiving how such a perverted view of professional morality could have arisen in the mind of a Member of this College. By failing to conform to rules that should regulate professional conduct, rules founded on concern for the public good, and on sound moral principles, you would, had the College not taken its present action, have brought dishonor on the College of which you are a Member, and discredit on the profession to which you belong. Having regard, however, to the motives that influenced you in your actions, to the fact that you were misled by others, to your full acknowledgment of the wrong you did, and to the promise you have given to the College in reference to your future conduct, the College has determined not to erase your name from the list of its Members, but has desired me as their mouthpiece to reprimand you and to admonish you that any deviation in the future from strictly honorable professional conduct will be followed by the severest punishment the College can legally inflict."

Notes from the Clinical Society of Maryland.—At the meeting of the Clinical Society, on Friday evening, January 8th, Dr. H. C. McSherry presented an interesting case of displacement of the heart to the left side. The apex beat is seen and heard two inches to the left of a line drawn perpendicularly through the left nipple. The first dulness is noticed one inch and a half to the left of the centre of the sternum. The man has phthisis, two cavities in the left lung, and the displacement is thought to be due to contraction of the lung drawing back the heart.

Dr. McSherry called attention to the fact that there are a number of cases reported of displacement to the right side, but very few of displacement to the left. He regarded this as a rare case.

Dr. F. West reported a successful case of "Laparotomy for Relief of a Femoral Hernia."

Dr. R. Winslow reported a similar case of "Laparotomy for Relief of a Supposed Inguinal Hernia." In this case the operation failed to confirm the previous diagnosis, and search was made for the cause of constriction, which was found to be probably due to pelvic peritonitis. The operations were much the same, save that Dr. Winslow used antiseptic precautions more extensively than did Dr. West, and his patient seemed to make a rather better recovery, no pus being found subsequently in the wound, while in the case of Dr. West a small amount was observed. It might be mentioned that in Dr. Winslow's case an additional operation was performed, namely, an inguinal herniotomy.

The Clinical Society is to be congratulated, as stated by the President, upon having two such important cases reported at the same meeting, and also on the fact that they are the first successful ones in this city. A considerable amount of discussion followed, of a nearly useless character, as to the relative merits, dangers, etc., of the two operations. The justifiability of the operation in general, its time of performance and other practical questions were not discussed. There was some difference of opinion as to *antiseptic* precautions be-

ing necessary or of any particular advantage. The general sentiment favored their use, though it was by no means proved that anything more than cleanliness was reached in either operation reported. The opinion is extensive, we think, that the so-called *antiseptic* plans of operating are not really *antiseptic*, but simply different degrees of cleanliness. The President, Dr. Tiffany called attention to the fact that in nearly, if not all cases of strangulated hernia vomiting occurred at the time of reduction or immediately after. Also that the pain in all these cases is referred to the umbilical region, and may lead to error in diagnosis, as had occurred in one of his cases.

Honoring the Memory of a Good Physician.—It is not often that the good name and good deeds of the physician, who labors earnestly and unselfishly for a community throughout a long professional career, are so highly honored and remembered as has been the case in the instance we are about to relate. Some months back we recorded the death of Dr. Wm. M. A. S. Maxwell, of Kent County, Maryland, and had occasion to refer to the eminent usefulness and worth of this lamented physician. We had known Dr. Maxwell for some years, and were therefore able to appreciate the high character of the esteem in which he was held by the community in which he had labored for many years. Our late friend combined in his character and training the salient points of the true physician and citizen, hence we are not surprised to know that his death has kindled the deepest regard for his memory among his friends and patrons. This regard has been manifested in the most expressive way. During the month of May last a number of citizens of Kent County, of both sexes, assembled, and after adopting resolutions expressive of their high regard for the deceased and their deep sympathy for his bereaved family, decided to erect a monument as a token of their love for him and as an indication of their appreciation of his excellence and usefulness as a citizen, physician and friend. A committee was appointed, and by June 1st $718.25 had been subscribed for this purpose. On December 22d this monument was unveiled, and an able address was delivered by the President of Delaware College, of which Dr. Maxwell was an alumnus, reviewing the life and character of the deceased. This tribute to the memory of Dr. Maxwell was just and appropriate. It goes to show that a good and useful life may make a deep impression upon the hearts of an appreciative community.

The Defeat of Mr. Erichsen for Parliament.—We have called attention, in a previous number, to the candidature of Mr. Erichsen, the eminent surgeon and author, for Parliament for the Universities of Edinburgh and St. Andrews. The eminent fitness of Mr. Erichsen for a seat in the Lower House, and the earnest manner in which he was conducting his canvass, induced us to hope that he might be a representative of the medical profession in the next Parliament. We regret now to have to announce Mr. Erichsen's defeat in the recent contest. *The British Medical Journal* says "the defeat of Mr. Erichsen for the University of Edinburgh signifies a loss of strength in the discussion of medical questions in the next Parliament, which is to be regretted. It was universally admitted that the return of a man of Mr. Erichsen's position, experience, and capacity, would have implied a great addition to the strength of Parliament in discussing medical questions, and all those questions of public importance in which medical knowledge bears a large part. His strength lay in Edinburgh, but, as is always likely to be the case in parliamentary elections, political considerations hold the first place in the minds of a great body of the electors; and it is evident that in one part of the constituency at least, St. Andrew's, the conservative element greatly predominated, and the moderation of Mr. Erichsen's political views did not save him at the poll."

Medical Honors.—During the past year our professional brethren in England have received a number of recogni-

tions from the Crown in the way of the much coveted titles of medical knights and baronets. The latest recipients of these honors have been Dr. G. E. Paget, of Cambridge, and Dr. William Roberts, of Manchester. Both of these gentlemen have occupied the highest professional positions, and are regarded as eminently worthy of the gracious favor of Her Majesty who has been pleased to recognize their eminent services to science by conferring upon them the distinction of Knight Commander of the Bath. For a long time these distinguished honors of the Crown were reserved for the eminent residents of London, but latterly the provincial cities of England have come in for an occasional recognition. On this side of the Atlantic, where we have no such recognition of eminent services to science or to humanity, we are disposed to believe that medicine can get along quite as well without as with titular honors, but in England, were such marks of distinction have their value, we are always pleased to learn that the medical profession is not overlooked in the distribution of the K. C. B.'s

Cæsarian Section Contrasted with Porro's Operation.—There seems to be no longer any doubt of the great value of Porro's operation over the old classical operation of Cæsarian section, nevertheless, we still find that a certain number of operators cling to the latter method.

The *British Medical Journal* (Dec. 26th) has collected 134 Porro operations in which there were 59 recoveries, whilst of 136 Cæsarian sections only 25 mothers survived. In the face of these strong figures our contemporary says, "We think that the obstetrician who does not discard the old classic operation for the modern method, inaugurated by the great Italian professor, takes upon himself a grave responsibility."

Miscellany.

Dystocia from Rigor Mortis in the Fœtus.—B. Jones, Leigh, Lancashire, writes to the *British Medical Journal:* "The following case is one of great rarity. Previously to its occurrence, I had never heard of a similar condition, and none of the books I had at hand made any mention of this state in the fœtus. Dr. Robert Barnes, however, to whom I communicated the case, has very kindly informed me that he has, in his *System of Obstetrics* (vol. ii, p. 578), made reference to this condition, and to its effect upon the labor, as follows: 'Deaths or impending death of the fœtus.' I am glad that my opinion of the cause of the difficult labor is in accord with that of so eminent an authority.

On the 30th of September last, I was called to a woman in labor of her tenth child by the midwife in attendance, who had been with her patient for several hours, during which the pains had been frequent, and the labor had progressed, although slowly, until the head reached the outlet of the pelvis, when it became arrested. As it had been in this position for an hour and a half, on my arrival, I at once applied the forceps, and brought down the head without much difficulty; as soon as the greatest diameter of the head had passed the outlet, and the occiput was external to the vulva, I removed the forceps, expecting that another pain would bring the head, but it remained stationary for sometime, although the maternal resistance was overcome, and required several very strong pains, assisted by considerable manipulation, before the whole head was born, and I anticipated the necessity of having again to apply the forceps.

After the head was delivered, there was again considerble difficulty attending the birth of the rest of the body. When traction was applied, a dense feeling of resistance was encountered, which suggested that we had do either with a case of malformation or some morbid state of the fœtus. As careful examination failed to reveal anything to account for the difficulty, greater force was used; and, after considerable and continued traction, the shoulders and the rest of the body were extruded; and it was seen that the whole of the fœtus was stiff and rigid, with the knees flexed, and in one or two

place slight desquamation of the cuticle, from commencing putrefaction.

On a detailed examination, the following condition of the fœtus was discovered. The lower extremities were perfectly rigid and semi-flexed, the muscles of the abdomen and back in the same condition as to rigidity. The arms were movable, though stiffly, but the muscles hard and indurated. The neck and spine, to about the fourth dorsal vertebra were indurated, but could be moved at this point as a hinge. The muscles of the head and face were also stiff and rigid, and the cause of the dystocia had evidently been here, the body not being able to adapt itself to the curves of the passages until the death-stiffening had been overcome. The condition of the child thirty hours after birth, was identical with the preceding description, except that the whole body was somewhat more flabby.

There can, I think, be no doubt that this was a case of true rigor mortis, and its rarity is sufficient excuse for recording it, though one may wonder whether this condition may not be sometimes overlooked, as such a condition in a still-born child does not seem a very remote probability.

Successful Resection of Intestine in a Case of Strangulated Femoral Hernia.—Dr. J. Clark Stewart reports in the January number of *The American Journal of the Medical Sciences* a successful case of resection of the intestine in a male aged sixty-eight suffering from strangulated femoral hernia. The peculiar feature of the operation was the non-excising of the V-shaped piece of mesentery usually recommended. This was to avoid the chance of cutting off any blood-supply to the remaining gut, which is one of the dangers of the V-incision.

As to the propriety of resecting the gut in this case, instead of opening and leaving it *in situ*, as is generally advised, Dr. Stewart's hospital experience of the latter measure had been so discouraging as to make any alternative preferable. He holds that the resection of gangrenous intestines in strangulated hernia is not such a forlorn hope as it is usually represented to be, when an old man, too stupid to understand his danger or his chances, and in bad condition physically and mentally, recovers after such an operation performed with the hospital house-staff as operator, assistants, and advisors.

Management of New-Born Infants.—In the maternity department of the Woman's Hospital, in Philadelphia, the management of new-born babes has been as follows: As soon as the head is born the eyes are washed with an antiseptic solution. When the body is born the child is left in the bed to await the expulsion of the placenta. No effort is made to remove the placenta under half or three-quarters of an hour; before this time it is generally expelled by nature. When the placenta is expelled, it is placed in a pan, and the child is wrapped up and laid away with the placenta still attached. The child is now left and the attention is given to the mother. After the mother is properly cared for, the child receives attention. By this time the pulsations in the cord have long since ceased. The cord is now cut, and the blood is "stripped" out of the stump, but neither end is ligated. The stump is not dressed, nor is any band put around the child's body. The child is neither washed nor dressed, only a diaper and a simple "slip" or gown is put on, and then it is warmly wrapped up and put into a little bed by itself. After twenty-four hours it is taken to the baby's bath room (which is properly heated) and there it is washed and dressed. The physician in charge says that since this plan has been adopted the babies get along much better. We were in the wards in this department about an hour, and during that time we did not hear a single cry from babies. They all seemed contented and happy and were doing well. We are convinced that washing the child immediately after birth, and keeping it half naked for a long time during the process of careful dressing is not good practice.—*Medical World.*

THE DOCTORS SHOULD BURY THE HATCHET.—The *Washington Star*, of December 29th, published the following extract from a letter written by Dr. Dudley Morgan, who is now in Paris, to a friend in that city, and dated December 18th, which shows the effect the want of harmony among members of the American Medical Association is likely to have upon the proposed International Medical Congress to be held in that city in 1877:

"The continued agitation and factional fight among the members of the American Medical Association is producing the most unfortunate results among the French physicians and surgeons of Paris. Many have already concluded that the meeting [of the International Medical Congress at Washington] will not be largely attended, and consequently not a success, and have therefore determined not to make the long journey to America. It will require the greatest harmony of action and often repeated assurances that no further difficulties remain to hamper or prevent the convening of the Medical Congress in 1887, to remove the bad impressions and opinions already formed. I have to but send the following extract taken from *Le Progress Medical*, of this week, to give you an idea of what is thought here about the likelihood of the next International Medical Congress:

'The next International Medical Congress *ought* to be held at Washington, in the United States of America in 1887. *But* for the last few months the American journals have been filled with the party discussions, which, if they are allowed still to continue, will compromise or render impossible the success of the Medical Congress. In the Journal of the American Medical Association we find the most complete account of the discord which reigns in the camp of our brethren of the United States. The other medical journals are equally taken up in this dispute, which for the last six months and which still continues to divide the medical fraternity and press of America. We cite among the other journals, which are far from accepting the views presented by the official organ of the American Medical Association—the *New York Medical Journal*, the *Philadelphia Medical Times*, the *Boston Medical and Surgical Journal*, the *Louisville Medical News*, the MARYLAND MEDICAL JOURNAL, the *New York Medical Record*, &c., without speaking of the English and German journals, which have written much on the subject.'"

THE TWENTIETH ANNIVERSARY OF THE BALTIMORE MEDICAL ASSOCIATION was celebrated on the night of January 11th, at the Eutaw House, in this city. The occasion was one of great social and professional interest and was largely attended by the members of the Association.

The collation was handsomely served by the proprietor of the Eutaw House. Toasts were offered and responded to by the officers elect, and other members as follows:

Toasts.—1. The Retiring President, Joseph T. Smith, M.D.; 2. The Newly Elected President, W. Frederick A. Kemp, M.D.; 3. The Ex-Presidents of this Association, John Morris, M.D.

Sister Local Medical Societies.—According to seniority of organization.—4. The Medical and Surgical Society, J. W. Chambers, M.D.; 5. The Clinical Society of Maryland, I. E. Atkinson, M. D.; 6. The Academy of Medicine, G. Lane Taneyhill, M.D.; 7. The Gynæcological Society, P. C. Williams, M.D.

Colleges.—8. The Medical Department of the University of Maryland, F. Donaldson, Sr., M.D.; 9. The College of Physicians and Surgeons, George H. Rohè, M.D.; 10. The Baltimore University, H. H. Biedler, M.D.; 11. The Baltimore Medical College, J. H. Scharff, M.D.

Officers.—Officers for the ensuing years were elected as follows: President, W. F. A. Kemp, M. D.; vice-presidents, I. E. Atkinson, M.D.; A. F. Erich, M.D.; recording and reporting secretary, J. M. Hundley, M.D.; corresponding secretary, H. H. Biedler, M.D.; treasurer, J. I. Pennington, M.D.; executive committee, J. L. Ingle, M.D., J. H. Scharff, M.D., and Jos. T. Smith, M.D.; committee of honor, J. E. Gibbons, M.D., S. T. Earle, M.D., and J. W. Chambers, M.D.

Overfeeding in Phthisis.—Many attempts have been made to arrest the development of the bacilli of tubercle by means of parasiticides, but hitherto without much success. For the last three years, Dr. Debove, of Paris, has endeavored, by means of a process of "overfeeding," so to improve the general nutrition of the tissues as to compensate for the previous loss from fever, expectoration, etc. For this purpose, he introduces, through an œsophageal tube, a chyme made by suspending meat-powder in milk, with the help of eggs. The meat-powder is thus prepared: several pounds of finely minced beef is thoroughly dried over a fire, and then pulverized. Twice or thrice a day, 100 grammes of this in milk were administered by means of the tube; and, under this treatment, the fever and diarrhœa disappeared, and, though the tubercular disease was not cured, the conditions of life were rendered more endurable. Dr. Peiper has repeated Debove's experiments in Professor Mosler's clinic in Greifswald, but has found himself able to dispense with Debove's irritating tube. The quantity of meat-powder was gradually increased to 300 grammes, which was given at meal-times along with a Hungarian wine or some stomachic. In fourteen cases, the result was very satisfactory, the weight of the patient increasing from five to twenty-two pounds; the cough and expectoration, too, decidedly diminished; and, in one case, the number of bacilli decreased. In three cases, gouty symptoms made their appearance, but there were no gastric troubles. Dr. Peiper attributes the failure of this treatment to effect a complete cure to the fact that all the patients were in advanced stages of phthisis, and he thinks that, if adopted earlier, it might, by improving the general condition, and giving more power of resistance to the lungs, render the poison of tubercle inocuous to the system.—*Br. Med. Jl.*

A Case of Dissecting Aneurism of the Thoracic and Abdominal Aorta. —In the January number of *The American Journal of the Medical Sciences*, Dr. James E. Graham, of Toronto, describes a case of dissecting aneurism of the aorta which presents many points of very great interest. The patient lived after the first formation of the aneurism, a period of more than thirty years. The strain was taken off by an opening low down between the artery and the aneurism, which rendered it possible for the blood to flow readily back into its channel. The aneurism extended throughout the whole length of the abdominal and thoracic aorta, and more than half the circumference of the vessel. The closing of openings in the inner coat, at the exit of arteries from the aorta, and the corrugated appearance of the inner surface of the aneurism, are also points worthy of notice in this remarkable case, which is an excellent example of the restorative power of nature, and demonstrates the possibility of the enjoyment of years of fairly good health in one suffering from extensive dissecting aneurism.

Resorcine in Epithelioma. — Dr. Rubino Antonio has successfully applied resorcine to an epitheliomatous tumor on the side of the nose of an elderly man. The tumor was itself only of the size of a pea, but was apparently attached to the bone, and was surrounded by an extensive area of reddened skin which was evidently infiltrated to a considerable distance. Under the circumstances, Dr. Antonio did not advise an operation, and at first feared nothing could be done. He, however, remembered some observations of Drs. Pascal and Manino, and decided to apply resocine locally. An ointment was prepared containing 15 parts of resorcine to 20 of vaseline, and after the tumor had been washed with permanganate of potash this ointment was applied twice a day. The discharge began almost immediately to diminish, and the growth became gradually smaller and smaller, till, after five months of this treatment, nothing was left, except a small white circular cicatrix.—*Giornale Internazionale delle Science Mediche. — London Medical Times.*

Medical Items.

Pepper's System of Medicine is being translated into the Italian language.

Dr. J. Orne Greene, one of the oldest and most respected of the physicians of New England, died at Lowell, Mass., on December 23d, in his 87th year.

The *Journal of the American Medical Association*, of January 9th, states that the Preliminary Organization of the Congress is at this time nearly complete.

The *Detroit Lancet* has dropped the name *Detroit* and will hereafter be known as *The American Lancet*. The *Journal* is to be conducted upon a more cosmopolitan basis.

Dr. John C. Fairfax, a practising physician of Prince George County, Md., is said to be by descent and law the eleventh Lord Fairfax. He is also Lord Camerden. Dr. Fairfax does not assume these titles.

It is stated by the *London Medical Times* that Dr. Austin Flint has consented to deliver the address in medicine at the next annual meeting of the British Medical Association, which is to be held at Brighton on the 10th, 11th, 12th, and 13th of August.

Mr. Am Ende, the unfortunate druggists of Hoboken, N. J., whose substitute of morphia for quinia in compounding a prescription led to the death of two persons, has been acquitted by the jury which tried the case. The verdict seems to have given much satisfaction to the citizens of Hoboken. It was claimed by Mr. Am Ende that he was suffering from mental overwork, which made him absent-minded and led to his doing mechanically the things he had to do.

The introduction of *cascara sagrada* into the *Pharmacopœia* has called renewed attention to a valuable remedy for habitual constipation, which is almost universally used in America. The various natural mineral waters possessing aperient properties, have been carefully studied, an impetus having been given to this branch of investigation by the publication, in book-form, of Professor Hay's well-known work on the action of saline purgatives. It is difficult to say to which member of the group the palm of popularity should be awarded, but the Friedrichshall water is most commonly prescribed by physicians. The difficulty of obtaining a thoroughly reliable laxative was long experienced, both by patients and their medical advisers.—*Br. Med. Jl.*

Dr. Edward Warren, of Paris, France, writes to the Baltimore *Sun*, under date of December 25th, that having addressed a letter to M. Pasteur inquiring how the benefits of his vaccination for the prevention of hydrophobia might be secured to persons bitten by rabid dogs in the United States, M. Pasteur addressed the following reply to his communication: "If such of your countrymen as have been exposed to the contagion of rabies will come *at once* to Paris I will treat them with pleasure, and, I believe, to advantage, notwithstanding the long interval which must elapse before their arrival. It will be necessary for them to remain under my care for eight or ten days, and for the present *the treatment will be gratuitous.*"

Nitro-glycerine has steadily made its way to the front, and has now an assured position as a therapeutic agent. Quite recently, Burzhiniski has published a valuable paper on its action in nephritis, showing that under its influence the urinary albumen eliminated by the kidneys is diminished, whilst the quantity of urine is increased. Rossbach examined the action of nitro-glycerine, nitrite of amyl, and the nitrites of potassium and sodium, and gave a decided preference to nitro-glycerine, speaking of it as an "excellent remedy" in interstitial nephritis, and one "calculated to prolong life." Its power of dilating the blood vessels is so marked, that it is now used in the treatment not only of angina pectoris, asthma, and Bright's disease, but for warding off shock in all forms. In America it has been proposed as a substitute for alcohol.—*Br. Med. Jl.*

Original Articles.

TWO CASES OF DYSTOCIA.

BY L. E. NEALE, M.D.

Chief of the Obstetrical Clinic and Demonstrator of Obstetrics in the University of Maryland.

Case I.—Mrs. B. W. American, white, æt. 25 years, 1 para. Labor at full term December 16th, 1885. Membranes ruptured 10 P. M., although real pains were not experienced until midnight. Os dilated regularly and completely by 4 A. M. December 17, Diag. L. S. I. A. breech movable above the superior strait. Descent failing, chloroform, manual extraction, Elliot's forceps, were resorted to by the attending accoucher, Dr. S., but with an unsuccessful result. Professor Miltenberger being summoned, arrived 7.45 A. M. and with the patient under chloroform tried (a) manual extraction, (b.) to pull down a foot, likewise unsuccessfully.

I was added to the consultation 8.30 A. M., and found the patient partly under chloroform, the os uteri dilated and retracted up over the presenting breech, which was still movable at the pelvic brim, and moreover the brim seemed to be slightly contracted in its antero-posterior diameter.

For fully half an hour did I make fruitless attempts at manual extraction. It was difficult to hook the finger tips in the groin and the invariable result of traction thereon was only to bring one hip a little down while the other ascended correspondingly above the superior strait. I then tried my utmost to reach a foot, but as both legs were thrown up straight along the anterior surface of the child, with the feet quite in the fundus uteri, and the womb clasping the child very tightly, this attempt also proved a failure. The cord could be felt pulsating fairly well, although the heart sounds could not be heard by external auscultation. Various methods to pass the fillet failed. Remembering with what favor Lusk (edition 1885) regards the use of Tarnier's forceps in difficult breech labors, when the breech is below the pelvic brim, and having myself already fruitlessly tried all safe means to effect delivery, I thought that even here with the breech above the brim, the forceps (almost as a last conservative resort prior to employing the dangerous blunt hook,) if cautiously used, might be permissible.

The instrument employed was the Lusk-Howard modification of Tarnier's forceps, which was easily introduced and locked, and at first seemed to hold well, but finally with stronger tractions slipped without, however, doing the slightest damage. I again resumed my former efforts at manual extraction with the finger hooked in the groin, but with the same unsuccessful result.

A second time did I attempt to reach the feet, and finally with much difficulty and at the risk of rupturing the uterus, I succeeded in bringing down one foot without doing any damage. As moderate traction upon this did not draw the breech through the brim, I brought down the other foot, after which extraction of the trunk was easily effected. Delivery of the arms, which were thrown up alongside of the head, and of the after-coming head, was a task of some little difficulty, and at last the patient was delivered, with perineum uninjured, of a large 10 lbs., well formed, asphyxiated female child, presenting a few bruises about the groins, after at least one hour's continuous manipulations by myself, not including the previous work of the other two physicians. The child was born limp and with pulseless cord, but as the heart could be felt to flutter feebly beneath the thoracic wall, and as a slight gasp was observed, I persevered in my attempts to induce respiration and finally succeeded by the aid of Schultze's method.

The third stage of labor was soon terminated, the perineum was uninjured, some trouble arose on the eighth puerperal day from which the patient is now out of all danger. * * * *

The following remarks may serve to indicate the line of discussion for the society, which, as best illustrated by the present case, I would suggest might aptly fall under two principal subjects, viz.

1st. Barnes's method of decomposition.

2d. The obstetric forceps, in difficult breech labor.

I purposely confine myself to a few citations from the best authorities, upon these two practically important points, not only as illustrated by the case, but also for the additional reason, which I trust you will bear in mind, that this report is not intended to be sufficiently comprehensive to embrace a discussion of all the causes and management of every possible difficulty that may be met with in presentations of the pelvic extremity.

Presentations of the breech alone, unaccompanied by the inferior fœtal extremities, *frank* breech (Pinard), *mode des fesses* (Charpentier &c.), have been particularly studied by the French; Tarnier, Chantreuil, Charpentier, Budin, Pinard, Cantacuzène, Lefour, Olivier, &c., "and in the writings of these different authorities are raised many points of interest."

"Both Lefour and Olivier agree, that the presentation of the pelvic extremity where the breech or nates alone offers, is that which most frequently requires the intervention of the accoucheur, and they both acknowledge the danger of that intervention for the child, whether it be either manual or instrumental."*

Most authorities attribute the cause of the dystocia in such cases to the fact of the breech being an inefficient dilator as compared to the vertex, its imperfect adaptability to the inferior uterine segment, hence the slowness of the first stage, the early rupture of the membranes before complete dilatation of the os, and escape of the liquor amnii with possibly prolapse and subsequent compression of the funis, either between the child's body or after coming head and the pelvic wall, and also extension of trunk, arms, head, occurring spontaneously or produced by art.

Futhermore, Tarnier† says: "The difficulty consists in the production of lateral flexion of the body by which disengagement is usually effected, and this is because the inferior extremities thrown up along the whole length of the trunk, form *splints* to the fœtal vertebral column, and maintain it rigid."*

As regards the management of such cases, the difficulty of prehension either manually or instrumentally is admitted by all, hence I bring the above teaching of the most recent French authority before the notice of the society as a very practical point that may indicate the proper line of treatment. For, if this teaching be correct I should think it would naturally lead us to adopt the plan so strongly advocated by Barnes in the last edition of his able work on obstetrics, published in 1885.

Barnes advises in breech presentations either at or above or below the superior pelvic strait, whether the legs are (*a.*) thrown up alongside the trunk as in the present case; or are (*b.*) flexed down by the breech; whenever interference becomes necessary for the delivery of the breech, the proper thing to do, is to bring down a foot or feet and thus decompose the wedge, after which extraction is facilitated. "We have on several occasion brought a live child into the world by this proceeding when forceps, hooks, and various other means had been tried in vain; this, we repeat it emphatically, is the right thing to do in the first instance. * * * It is of no use to attempt to bend the leg by acting upon the thigh or knee, the finger must be applied to the instep and therefore carried nearly to the fundus of the uterus; no ordinary case of turning involves passing the arm so far."†

Nevertheless, if the finger can be hooked in the groin, no matter whether the presenting part be at or above or below the superior strait, for my own part, I would not utterly ignore the practice of making careful, yet strong traction upon the breech, aided by external pressure over the opposite extremity of the fœtal ovoid; and, hence, I think this method is at least deserving of a fair trail in appropriate cases, especially where, as in the present, Barnes's method could not at first be performed.

*Charpentier: "Taite Practique des Accouchements." Edition 1883, vol. II pp. 856-7.

†Tarnier and Chantreuil: Traite de l' Art des Accouchements. Edition 1882, vol. I, pp. 669-70.

*Charpentier, vol. I, p. 448, says: "That both engagement and disengagement of the breech either do not occur at all, or occur too slowly."

†Barnes: "System of Obstetric Medicine and Surgery." Edition 1885, pp. 809, et seq.

In speaking of the management of this variety of breech presentation, Leishman* says: "It is sometimes possible, and the more so when the breech is high in the pelvis, to break up the presentation by pulling down one leg." Playfair† says: "If, however, the legs be extended on the abdomen, it will be necessary to introduce the hand and arm very deeply, even up to the fundus of the uterus, a procedure which is always difficult and which may be very hazardous; nor do I think, that the attempt to bring down the feet can be safe when the breech is low down and fixed in the pelvic cavity." I am strongly inclined to agree with this last statement, although I have yet to test it clinically.

Zweifel‡ advises; when the breech is movable above the brim to pull down the anterior foot; and adds, that when the breech has entered the true pelvis this plan should be rejected because of the danger of fracturing the thigh; here we must make extraction directly upon the breech, (*a.*) manually if possible; (*b.*) instrumentally, using first the fillet, second the blunt hook.

Schroeder§ says: "We should not give up all hope of bringing down a foot even when the breech has entered the pelvis, for here, aided by position of the woman, while one hand manipulates internally, we can sometimes succeed in pushing up the breech and then decompose the wedge;" and I am inclined to think this should be tried before resorting to instruments.

Lusk¶ says: "In a few cases, influenced by Barnes's teachings, I have under the most difficult conditions succeeded in bringing down a foot; nevertheless, I would advise the utmost caution in practicing the method and that in all cases the operator desist the moment address fails and force becomes necessary."

This counsel from the most recent and practical American authority applies to the case in question where during my first attempt at Barnes's method address failed, force became necessary, hence I desisted, and it was only after the uterus had become sufficiently relaxed during the time occupied in the performance of other measures narrated, that I finally succeeded. Without delaying with the fillet, the blunt hook, etc., as not illustrated in the present case, I shall pass on to the other principal means here adopted to which I especially desire to invite the consideration of the society. I refer to the application of the obstetric forceps to the fœtal pelvic extremity. Fearing that some may at the very outset be inclined to censure this practice as unjustifiable, let us look at the writings of the authorities.

Zweifel says: Levret was the first to advise the application of the forceps to the breech; hence, this practice must have been known almost as early as the instrument itself.

Jacquenier declared: "it is inexact to state that the forceps would crush the pelvic bones and inevitably kill the fœtus by bruising and lacerating the abdominal viscera."*

Tarnier† stated: "that under exceptional circumstances neither Stoltz nor Dubois feared to apply the forceps to the breech; and added, that he had a number of times imitated their practice with success for the mother and sometimes for the child. When the fœtus was dead, he assured himself at the autopsy that the forceps had produced no lesion either of the pelvic or abdominal viscera."

Hüter‡ "declares: that no better instrument exists for the extraction of the breech." In our own country, Lusk, Taylor, Agnew, Miles, Fruitnight, Rochester, Kales, etc., etc., have all published successful cases.

Lusk says: "since the invention of axis traction by Tarnier a new impetus has been given to the method.

*Leishman: Edition 1879, pp. 326.
†Playfair: Edition 1885, pp. 319.
‡Zweifel: Lehrb. d. Operativen Guburtshulfe: Edition 1881, pp. 216.
§Schroeder: Lehrb. d. Geburtshulfe, Edition 1880, pp. 309.
¶Lusk: Edition 1885, pp. 378

*Lusk: "Science and Art of Midwifery." Edition 1885, pp. 379.
†Tarnier: "Dictionnaire de Medecine et de Chirurgie." 1872. Lusk.
‡Huter: "Obstetrical Operations" Leipsic. 1874. Lusk.

With axis traction not only is the resistance offered by the parturient canal diminished, but as Pinard states, the pressure is regulated and not increased by traction. The fœtal part is seized solidly and with the least risk of harm." Successful cases are reported with this instrument by Olivier, Budin, Thomas, Berthout, Lobat, and Cayla.

In the case the subject of this report, Tarnier's forceps was applied to the breech movable at the brim and they slipped, yet the only bruising noticeable post-partum, was situated in or about the flexure of the groins, and consequently was produced by the finger during the efforts at extraction. Perhaps some one may suggest that this was rather good luck than good management, that I did not make sufficient compression with the forceps, hence, the absence of serious injury to the child and the slipping of the instrument; be this as it may, I believe I erred on the safe side, and certainly the result gives me no cause for regret. Even when applied to the head we all known how common it is for the instrument to produce minor injuries, and fortunately far more rarely, compression and fracture of the cranial bones, serious damage to the eyes, etc., as well as to the maternal structures. The dangers attending the use of the fillet and blunt hook in breech labors are freely admitted by all authorities, hence we are naturally driven to seek easier and safer means. Miles* preferred the forceps for the following reasons:

1st. The breech forceps are not difficult to apply.

2d. By their use, rotation can be easily accomplished if required.

3d. With them we have tractile power sufficient to effect delivery.

4th. By their proper use the mother or child will not be injured.

5th. There is the same philosophy, with the exception as a compressor, in the applications of breech forceps as a means of effecting speedy delivery in breech cases, as there is in the application of head forceps in head presentations.

*Miles: *American Journal Obstetrics*, vol. xii, pp. 135 et seq.

In the case under consideration you will remember the forceps was applied to the breech movable at or above the superior strait, which at the time, I was fully aware was not advised by most authorities. However, here also I find I can meet adverse criticism with the counsel of Olivier, whose writings are based not only upon his own experience, but also upon clinical facts taken from the most eminent French obstetricians and consequently must have considerable weight. Olivier† teaches: that the forceps may be applied (*a.*) *to the breech at the superior strait;* (*b.*) *to the breech more or less engaged;* (*c.*) *when it is at the vulva.* The same author continues: "When the breech is at the superior strait, the os dilated, and the membranes intact, (*a.*) rupture them, (*b.*) pull down a foot, and wait; if the breech does not engage, (*c.*) make extraction. If the membranes are already ruptured and it becomes necessary to interfere, try at once to bring down a foot and if successful make extraction, if unsuccessful apply the forceps; should they slip, make the extraction by means of the fillet carried over the anterior groin." Olivier says "*the forceps should be applied as much as possible over the thighs and not over the pelvis*," yet, Lusk applied the forceps "over the sacrum and the anterior surface of the thigh," which would seem to me to give the instrument a firmer purchase.

Barnes advises decomposition even when the breech has entered the pelvic excavation and both feet are thrown up in the fundus‡ which, if at all possible I should think must certainly be a very difficult if not dangerous manœuvre. Here, I should decidedly prefer to try (*a.*) digital or manual extraction; (*b.*) forceps; (*c.*) fillet, abdominal pressure being used with all, before resorting to so hazardous a measure. Of course, when a foot is flexed down by the side of the breech, no matter what position the breech occupies in the pelvis, other things being equal, I should at once resort to decomposition: but where the breech or nates alone present, in the

†Charpentier· Edition 1883, vol. II, p. 180
‡Barnes: Edition 1885. Diag. 206, p. 807.

light of our present knowledge, I should prefer as the safest and most practical means of effecting artificial delivery, (*a.*) manual or digital extraction with the finger hooked in the anterior groin or if possible the entire hand grasping over back of the sacrum; and failing in this, (*b.*) decomposition; (*c.*) forceps; (*d.*) fillet; (*e.*) blunt hook.

Case II.—Mrs. McK., Irish, white, æt. 30 years, III para, short, very stout, and of the most powerful physical organization. Accustomed to hard physical labor from childhood, she enjoyed excellent health with the exception of slight menstrual disorders. After marriage, her second and third pregnancies followed close upon the first, at intervals of ten months each; gestation being always perfectly normal. Her first and second labors at full term were very difficult, and were both terminated by high forceps (Hodge) operation, the child on each occasion dying during delivery.

Her third labor at term began Thursday, December 18, 1885, about midnight. At ten A. M. the following day the membranes were ruptured by a midwife, probably before full dilatation had been accomplished. Dr. J. B. B. was summoned at seven P. M., and found the woman in "hard labor," vertex presenting, R. O. I. P. head movable at superior strait, os dilated, anterior lip very œdematous, soft parts hot and dry, patient "nearly played out." Remembering his past experience with her, the Doctor at once called Dr. Wm. D. B. in consultation, who administered chloroform, while Dr. J. B. B. applied Hodge's forceps, which slipped once, twice, three times! Dr. Wm. D. B. then tried, with a like result, and still again with Elliot's forceps, which also slipped. Internal podalic version was then attempted and failed. Both feet were brought down to the superior strait, a cord was tied over one foot, and although the head could be moved above the brim, the uterus clasped the child too tightly to permit turning. During these manœuvres the funis became prolapsed and soon ceased pulsating. I was added to the consultation about midnight, *i. e.*, some twenty-four hours after the commencement of labor. I found upon examination the vagina short, hot, dry, and swollen; pulseless funis and the cord attached to the foot both hanging in the vagina; os dilated, anterior lip œdematous, head movable above brim, R. O. I. P., lassooed foot beside the head, membranes ruptured, waters thoroughly evacuated, uterus rigidly contracted and retracted. The pelvic brim just admitted the passage of my folded hand, *i. e.*, was contracted to two and three-fourths ($2\frac{3}{4}$) inches antero-posteriorly, (certainly not over three inches); the symphysis pubis measured over two inches in length (probably nearer two and a half inches), and had an exaggerated inclination, with marked shortening and narrowing of the pubic arch. All the bones were thick and massive.

Upon learning the foregoing history, I at once advised craniotomy, and with the patient under chloroform, performed the same with the trephine and cranioclast. The bones of the skull being very thin, offered little resistance and tore away piecemeal. Thus I worked for at least one hour and a half with cranioclast and blunt hook (both of Braun), but could not bring the hard base of the skull through the contracted brim. I then desisted, and trusting to nature's efforts, I temporarily left the patient, who was in excellent condition, trusting that when she thoroughly revived from the chloroform, which had already been intermittently used for five or six hours, she might effect the expulsion of the diminished head without further assistance. This hope, however, was not realized, and I again resumed my arduous labors. Chloroform was now withheld, as I feared some trouble might follow such a prolonged administration. After another half hour's work I finally accomplished the delivery of the head by the aid of Braun's blunt hook caught over the posterior angle of the lower jaw bone, thus tilting the base of the skull and dragging it through the contracted pelvic brim, and effecting its complete extraction with the hook in the anterior or mental angle of the inferior maxilla. The most powerful tractions upon the head,

aided by abdominal pressure, failed to draw the shoulders through the brim, and this was at last accomplished by the aid of the blunt hook caught in the axillæ. No difficulty was experienced with the remainder of the body, although the child was of large size and must have weighed about ten pounds. Ergot and a copious, hot, carbolized intra-uterine douche were administered, a perfectly normal puerperium followed, and the woman is now well and hearty.

I am of the opinion that Tarnier's basiotribe might have been of service in this case, but the one I ordered, and hoped to exhibit at this meeting, has not yet arrived.

Subsequent examination of the woman demonstrated the absence of rachitis; the early history was not of this disease, the body bore no evidence of it, and the external pelvic measurements were perfectly normal. As accurately as I could estimate during labor, the pelvic brim measured two and three-fourths inches (certainly not more than three inches) in its antero-posterior diameter. The available space in the pelvic cavity was further encroached upon by the increased length, nearly or quite two and a half inches, and inclination of the pubes, the narrowing of the pubic arch, and the thick massive structure of the bones. As I have said, the vagina was short, and during labor the soft parts were dry and swollen, besides a marked œdema of the anterior lip, all of which conditions made additional complications.

I shall not be so unkind as to occupy the time of the Society, and especially of those gentlemen who are to follow me, by discussing all of the many interesting points connected with this case. However, I trust the brief mention of a few may be pardoned.

1. The comparatively short interval of ten months between the confinements.

2. Pelvic mensuration. The character of the pelvis: flat, non-rachitic, with exaggerated length and inclination of pubes, with shortening and narrowing of the pubic arch, and increased bone development.

3. The fact of difficulty increasing with succeeding labors. This has been explained; (*a.*) by the laxity of the abdominal muscles in multiparæ failing to sustain the uterus in its proper relations to the pelvis, thus favoring mal-presentations and mal-positions, and also failing to aid the expulsive efforts of the 2nd stage. (Spiegelberg): (*b.*) the increased size and hardness of the fœtal head (D'Outrepont), not applicable here: (*c.*) the increased maternal deformity: (*d.*) and in the present case, the early rupture of the membranes, evacuation of waters, and rigidity of uterus.

4. The best means of effecting delivery at full term in such cases.

5. The induction of premature labor.

* * * * * *

It is only to these two latter eminently practical points I desire to invite particular attention.

(1.) With a living child at term and pelvis admitting of its possible extraction alive, the head movable at or above the superior strait and turning practicable, we are at once confronted by that much vexed and eminently practical question of version or high forceps. Hence, even at the risk of reopening a recent discussion among us upon this subject, I cannot refrain from mentioning such an important point, at least in so far as it appertains to the present case. In discussing Dr. Miltenberger's paper on "Version and High Forceps" at the meeting of this society, held November 10, 1885, Dr. P. C. Williams said: "The child may be of normal size and the pelvis abnormally narrow, or the pelvis normal and the child abnormally large. In either of these cases he would choose forceps rather than version."*

I shall not attempt to quote all of the highest authorities I find opposed to this view, for the very first standard text-book I open (Playfair, Ed. 1885, p. 397) tells me: "The most generally received opinion in the present day amongst scientific obstetricians, is that in the simply flattened pelvis, with antero-posterior diameter of not less than 2¾ inches, turning is the preferable operation." Barnes (Ed. 1885, p. 840) says: "Generally, however, from 3.25 inches to 3.50 inches, or a little

*Maryland Medical Journal, Dec. 5, 1885, p. 504

more, is the working range for a child at term." He considers version "is justified in cases of contraction that admit of the passage of a living child, and it is further justified in cases of contraction to a certain though small degree of contraction beyond this, which admits of the passage of a dead child."† He describes the operation fully; he gives in italics the affirmation of Bandelocque as the main mechanical argument for the operation, (also so strongly insisted upon by Sir J. Y. Simpsom) that, "*the head will come through the pelvis more easily if drawn through base first than by crown first.*"‡ He states that Osiander, Hohl and Simpson insist upon this fact, which is disputed by McClintock and E. Martin, and from his own personal observation he reports (p. 840) several cases to prove its truthfulness. Yet, under the head of General Appreciation of the Operation (p. 842), he says: "Subsequent experience of Robert Barnes and the independent experience of Fancourt Barnes, especially with the axis-traction forceps of Aveling and Tarnier, have compelled him to prefer the forceps, and this should be tried first." Thus, from this, the most recent English writer on obstetrics, authority may be quoted in support of either side of the question, and an unprejudiced reader may be left in doubt. Lusk, who was one of the first, if not the first, to introduce the axis-traction forceps of Tarnier into this country, and whose advice is universally regarded as most eminently practical, says: (Ed. 1885, p. 504) "So long as the head does not engage at the brim, there is no rivalry between version and forceps. The latter should be placed under the ban as hardly less dangerous than the Cæsarian section. The advantages of version in contracted pelves grow out of the unquestioned fact, that the after-coming head passes more readily the contracted brim than the normal head-first presentation. This superior facility is attributable to the entry of the head by its smaller bi-mastoid diameter!" In support of this opinion I might go on to quote an overwhelming amount of authority, but as this subject has already been so ably discussed in the recent paper above referred to by one in every respect so much more qualified than myself, I feel in courtesy forced to close, with the simple statement that in my humble opinion, should the case herein reported again present herself at full-term with living child offering head first, I should at once resort to version if practicable, as in the light of our present knowledge and her own past history, the best and safest mode of effecting delivery of a living child. If extraction of the after-coming head should not be possible, then craniotomy upon the after-coming head as a last resort. If version should be impracticable, with living child, the axis-traction forceps may be cautiously tried before resorting to craniotomy, but with dead child, craniotomy at once. As regards the question of performing craniotomy upon a living child, Barnes says: (Ed. 1885, p. 845) "If it be admitted, and the conditions of the case involve these postulates: (1), that the child cannot come through alive; (2), that the operation is undertaken in order to save the mother, waiting till the child is dead is opposed alike to reason and to humanity. It seems a refinement of casuistry to distinguish between directly destroying a child, and leaving it exposed to circumstances which must inevitably destroy it; and it is risking the very object of our art to wait for the lingering death of the child until the mother's life is also imperiled."*

(2.) Now, let us consider the question of premature labor. Should this woman present herself with living child before the full term of gestation, ought labor to be induced as soon as the child becomes viable? In view of the fact that the patient is under medical observation this question is eminently practical, and for my own part I should unhesitatingly answer it in the affirmative. Playfair says: (Ed. 1885, p. 398). "The established rule in this country is, that in all cases of pelvic deformity, the existence of which has been ascertained

†Barnes: Ed. 1885, p. 839
‡Barnes: l. c., p. 840.

*For "The Roman Catholic View of Craniotomy," see letter of A. Sabetti, S. J., *Med. Record*, November 28, 1885, p. 606.

either by the experience of former labors, or by accurate examination of the pelvis, labor should be induced previous to the full period, so that the smaller and more compressible head of the premature fœtus may pass where that of the fœtus at term could not. The gain is a double one, partly the lessened risk to the mother, and partly the chance of saving the child's life."

Lusk says: (Ed. 1885, p. 494-5.) "The induction of premature labor in pelves having from two and three-quarters to three inches conjugate diameter, possesses the merit of diminished risk to the mother and affords a chance of saving the life of the child. Below two and three-fourths inches the chances of saving the child by premature labor are too slight to be weighed in the balance." Most authorities support this opinion especially Spiegelberg, Litzmann, Dohrn and Milne. Although the infant mortality in these cases is naturally very large, "inasmuch as under three inches, the only operations which come into competition with premature labor are the Cæsarian section and craniotomy, a small saving of fœtal life is a powerful plea in its justification. But a stronger argument in its favor is the fact that the induction of premature labor offers a milder procedure, which within certain limits, inures to the benefit of the mother." Between the thirty-second and thirty-fourth week of gestation is regarded as the most favorable time for the operation.

According to the measurements of Stoltz, at this time the bi-parietal diameter of the fœtal head is somewhere about two inches and three quarters; from the thirty-fourth to the thirty-fifth, three inches; and from the thirty-sixth to the thirty-seventh, three inches and one-third. We all know, however, the uncertainty in determining the exact date of pregnancy, and in this connection if we either fall short of or go beyond the mark the danger increases in either case; in the first instance to the child principally, in the second to both mother and child. Barnes suggests as the safest course to count 230 days from the last menstrual epoch and add twenty days for a margin of safety. He has also "proposed combining version with premature labor, in pelves of less than three inches conjugate as a means of accelerating delivery. Milne by this method extracted a living child through a two-and-a half inch pelvis, and Budin has found by experiments with artificial pelves that a much less amount of traction force is requisite to drag the head of a premature child through a flattened conjugate by the feet, than by the forceps in cephalic presentations."*

"*The Introduction of a Bougie Into the Uterus*, sometimes called Krouse's method, is of all methods, that which combines certainty and safety in the highest degree.†

A CASE OF CARDIAC DISPLACEMENT TO THE RIGHT SIDE.

BY W. J. JONES, M. D.,

Resident Physician of Bay-View Asylum.

For the publication of the following case I am indebted to Prof. I. E. Atkinson.

Joseph E., German, aged 56 years, baker by trade, was admitted into Bay-View Hospital on the 30th of September, 1885. He was suffering with a profuse diarrhœa, which could never be entirely checked. His family history, though imperfect, pointed to no constitutional disease. He was a strong, healthy man up to April last, at which time he was taken with chills and fevers. This compelled him to give up his work. He gradually became worse, fever and night sweats made their appearance, and this was accompanied with a considerable cough. He lost flesh rapidly. At the date of his entrance into the hospital he was very weak, pale and emaciated. Inspection of his chest showed that there was a marked depression beneath both clavicles, and when he took a full inspiration the right side of his chest did not move with the same facility as the left. Measurement of the chest showed

*Lusk· Edn. 1885, p. 495.
†Barnes: Edn. 1885, p. 868.

that the right side was slightly larger than the left. Marked dulness was found over the greater portion of the right lung, both anteriorly and posteriorly. Cavernous respiration distinctly heard over an area about the size of the palm of the hand, situated just beneath the inferior angle of the scapular on the right side, moist râles heard elsewhere in the lung. The left lung was apparently healthy, though there was some evidence of emphysema. The cardiac impulse was seen to the right of the sternum. The chest walls being very thin a distinct pulsation could be seen, about an inch and a half to the right of the sternum, in both the second and fourth intercostal spaces. The pulsations in the fourth space seemed to be the apex of the heart. Patient did not remember ever having had pleurisy, nor did he know how long this displacement of his heart had existed. Auscultation over the area occupied by the heart showed the presence of a systolic murmur. This murmur was not eliminated, in consequence of the malposition of the heart. The evidence of phthisis being present, he was put upon supporting treatment, but in spite of it, he rapidly failed in strength, and died quite suddenly on November 16th. The autopsy was made by Dr. Councilman about sixteen hours after death, and revealed the following:

Body small, slightly built, emaciated and pale. The left side of the thorax more voluminous than the right. In the abdominal cavity a considerable quantity of clear serum. On the removal of the sternum the left lung was found collapsed and the left pleural cavity was free from adhesions. The lung was very voluminous. The pericardium was drawn over to the right side and intimately adherent to the right lung. On opening the pericardium, in the collapsed condition of the left lung, the apex of the heart was seen to lie one and a half inches to the left of the medium line. On replacing the heart in the pericardium, close to the right side, in the position it must have occupied during life, the apex fell beneath the sternum and slightly to the left. The heart occupied about its normal relations, with the exception that it was slightly turned to the right, and the left ventricle was more prominent. The base of the heart and the great vessels were also pulled over to the right side, this being very perceptible on the aorta. The heart was, in view of the emaciation of the man, slightly larger than normal, the enlargement being due to a dilated and slightly hypertrophied right ventricle. The aortic valves were slightly thickened and calcified, but did not show any stenosis or insufficiency. The entire aorta atheromatous to a high degree. The right lung not more than half its normal size and intimately adherent both to the pericardium and to the chest walls. The pleura very much thickened. The lung was indurated, thick, dense bands of cicatricial tissue extended from the pleura into the lung, and there was a great increase of connective tissue around the bronchi. There were several large communicating cavities in the lung; the walls of these in some places were caseous, and elsewhere caseous nodules were seen. The left lung was voluminous, very thin, poor in substance and emphysematous. The emphysema chiefly concerned the anterior edge. There were numerous small caseous nodules scattered through the lung, which could easily be felt beneath the pleura.

The interesting feature of this case is the marked displacement of the heart and the cause which brought it about. It is a well-known fact that displacement of the heart can, and does, take place in any direction, and it is only when the displacement is in a marked degree that our attention becomes especially directed to it. In this case it seems to be pretty clear that the primary trouble was pleurisy, and that the intimate adhesion of the lung to the pericardium on the one side and the chest walls upon the other was caused by it. It is more than probable that during the attack of pleurisy a considerable amount of effusion took place, which compressed the lung to a marked degree, and that the damage to it was never repaired. Then, as the inflammation subsided, the lung being firmly adherent, retraction took place, more and more, and pulled the heart

to the right side by traction. It is also probably that in addition to this the increased expansion of the left lung, which probably went hand in hand with the contraction of the right, might have assisted in the displacement. The pulsation seen during life must have been the right ventricle, as the apex was found, post-mortem, behind the sternum. The slight, though evident hypertrophy of the right ventricle, was most probably due to the destruction of lung tissue both in the indurated lung and in the emphysematous one.

Correspondence.

LAPAROTOMY FOR INTESTINAL OBSTRUCTION.

Editor Maryland Medical Journal.

Dear Sir: In your issue of January 16th, appears an editorial notice entitled "Notes from the Clinical Society of Maryland," which fails to do justice to one of the most remarkable sittings of this society, and in many respects does absolute injustice to the gentlemen who took part in the proceedings. In the first place Dr. West did not report a laparotomy for the relief of a femoral hernia, but for the relief of intestinal obstruction, the seat of which could not be diagnosticated until after the abdomen was opened, when it was shown that the obstruction was at the femoral ring. In regard to the case reported by myself, laparotomy positively was not performed for the relief of a supposed inguinal hernia, but for intestinal obstruction, the nature and seat of which was absolutely not even suspected until the abdomen was opened. Certain conditions found within the abdomen and the fact that a protrusion which seemed to be an injuinal hernia, and which could not be made to disappear caused me to explore the groin, previous to seeking elsewhere for the seat of constriction, a sac without intestine but containing tissue resembling omentum was found. The obstruction was found to have been due to an adhesion of six inches of ileum in the bottom of the pelvis between the rectum and uterus. I am sorry that in the opinion of the reporter, the discussion was of "a nearly useless character," and when the official report of the proceedings appears I think it will be seen that it was eminently practical and useful. The lucid remarks of Profs. Michael and Tiffany are sufficient guarantee that the discussion was not useless. I think "the justifiability of the operation in general, its time of performance, and other practical questions" were pretty thoroughly discussed by myself and others. It may not have been proved to the mind of your reporter "that anything more than cleanliness was reached in either operation," and "that the so-called antiseptic plans of operating are not really antiseptic," but if the use of bichloride of mercury solution 1-1000 for disinfecting hands, operation field and instruments, of silk, catgut and sponges which had been indefinitely kept in strong sublimate or carbolized solution, of boiled water carbolized for sponging and for cloths for wrapping up the intestines, and of pure iodoform and iodoform gauze as an external dressing do not constitute a rigidly antiseptic plan of treatment, I would like to be informed what does. The case which I reported certainly affords a suggestive commentary in regard to the use of antiseptics; an uninterrupted recovery, with scarcely a trace of fever, no pus, and firm union when the stitches were removed.

I remain with great respect,
Yours sincerely,
Randolph Winslow.

No. 1 Mount Royal Terrace,
Jan. 16th, 1886.

Note.—The "Notes from the Clincal Society" to which Dr. Winslow refers were prepared by a member of the Society, who was in attendance upon this meeting. As the Editor of the Journal was not present at the meeting referred to, he took it for granted that the facts as stated by the Journal's reporter were correct.

The object of the "Notes" was to call attention to the great interest of the meeting and to emphasize the interesting fact that two successful laporotomies for intestinal obstruction had been successfully performed for the first time in the history of our city. We regret, that in the preparation of these "Notes" our reporter should have done an injustice to the Society or to the gentlemen who took part in the proceedings. Such was just the reverse of our reporter's intentions and certainly not the aim of the article published by the Journal.

Editor.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

REGULAR MEETING, HELD DECEMBER 18, 1885.

The Society was called to order by the Vice-President, Dr. N. G. Keirle, in the Chair.

After reading and adoption of the minutes, Dr. Gardner and Dr. Free were elected members of the Society.

Dr. B. S. Roseberry exhibited a case of

ANOMALOUS CONDITION OF THE GUMS.

It occurred in a negro child 3 years of age, who, at the age of about 7 weeks, had an attack resembling chicken-pox, after which the child continued in bad health until about 7 months ago.

There was no reason for suspecting mercurial toxæmia or scurvy. No history of syphilis. The child was, however, decidedly rachitic, the long bones of the lower extremities showing the charracteristic bowing. The appearance of the gums was very peculiar; they were swollen, darkened in color and of a spongy consistence; the teeth, which remained in place, were very much loosened, and could readily have been removed by the fingers; several had already either dropped out or were pushed from their places. The cavity left after the removal of a tooth was quickly refilled by what appeared to be a hernia of soft tissue. This condition of the gums has already existed for 3 or 4 months. The treatment has consisted of tr. myrrh locally and liq. potassii arsenitis internally.

Dr. Wm. H. Norris has seen several such cases, and has always had the best results from the local application of a solution of phenol-sodique.

Some few months ago he saw a lady, æt. 65, of fair constitution, who had recently had made a new set of artificial teeth, which, after a few weeks use, gave rise to pronounced mercurial salivation. He ordered her to dispense with their services for a time, when the trouble disappeared. They were again introduced with the same result. He again ordered their removal, when the trouble disappeared. After a short interval she concluded to give them another trial, but before she had worn them only a few days, the old symptoms reappeared, and were only caused to disappear by completely abstaining from wearing the teeth.

Dr. A. Friedenwald then read a paper on

OPTIC NEURITIS ACCOMPANIED BY BRAIN SYMPTOMS.*

Dr. Hiram Woods thinks Dr. Friedenwald's paper valuable because it calls attention to the existence of optic neuritis without brain symptoms, as well as a relation that seems to exist between this trouble and interference with the menstrual functions.

He related a case of a female who had a choked disk and at the same time menstrual disorders. Neither syphilitic nor brain symptoms were present. She recovered on the use of iodide of potash after 3 months. He had seen iritis occur as an accompaniment of menstrual troubles. Iron internally and atropia to the eye accomplished a cure.

Another case of optic neuritis came under his notice; he attributed it to brain trouble, from which the patient had suffered. This case died; there was no autopsy, but she had marked cerebral symptoms.

Another case of vomiting and vertigo, in a girl, was accompanied by optic neuritis. Recovery was complete in this case.

Dr. J. W. Chambers said that, according to Gowers, next to cerebral tumors, lead poisoning and essential anæmia were the most frequent causes of optic neuritis.

Dr. B. B. Browne said that insufficiency of menstruation with dysmenorrhœa, imperfect development of the cervix, prolapse or fixation of the ovary, and retroversion of the uterus were the pelvic disorders, which most frequently gave rise to eye troubles.

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*This paper will be published in the *American Journal of Medical Sciences.*

Dr. DeWolfe thought that exposure of the eyes to intense heat was a prominent factor in producing this affection.

Dr. A. Friedenwald said that in writing his paper it was his object to call attention to the fact that there are causes for optic neuritis other than those arising from cerebral troubles.

Dr. R. Winslow then related a case of

PENETRATING WOUND OF THE THORAX FROM EXPLOSION, TRAUMATIC EMPYEMA, OPERATION, RECOVERY.

Jim Gallagher, æt. 19, admitted to the University Hospital, July 8th, 1885. Injured by the premature explosion of a blast. Face, body, and extremities peppered with powder.

Two large holes with charred edges are situated over the ensiform cartilage, and communicate with the right pleural cavity. Air is drawn in and out in respiration. The chest on the right side is tympanitic and the respiratory murmur is absent. There is no cough. Some bleeding from the wound at the time of admission. The patient when admitted was in a condition of propound shock, with cool skin, rapid feeble pulse, but was quite conscious. The next day the condition was very much the same; the respiration was rapid, but the pulse was only 90 and the temperature 99° F. Whiskey in small quantities was given and the wound occluded with iodoform and oakum. The temperature subsequently was variable, but never high. About the eighth day a severe secondary hemorrhage occurred, and again on the eighteenth day, from which he was placed in very great peril. The bleeding was stopped by plugging the wound. On the tenth day a large deep hole led down to the pericardium through which the heart's pulsations could plainly be seen. Percussion was dull over the right lower half of the chest. For the next month the patient's condition was very critical, with variable temperatures, sometimes reaching 103° F. Pulse and respiration much increased in frequency. In the meanwhile the physical signs of empyema became more and more distinct, and the necessity of evacuating the pus more apparent. August 20th, about six weeks after the receipt of the injury, the patient was etherized and about an inch of rib, probably the ninth, was excised posteriorly, when after breaking down some old adhesions, the pleural cavity was entered and a large quantity of pus evacuated. The cavity was thoroughly irrigated with a hot corrosive sublimate solution, 1 to 5000. A drainage tube was introduced and the wound dressed antiseptically. Under the influence of free drainage the temperature rapidly fell and the anterior wound soon healed. The tube was removed when the discharge ceased and the posterior opening soon closed.

December 16th, the patient is entirely well at this time, his wounds are quite healed, and the respiratory functions normal. The lungs expanded promptly.

Dr. Winslow said the prognosis for empyema was better in the young, than in those whose bones were completely ossified, for in the case of the young, the elastic ribs were able to sink in so as to come in contact with the lung, but if the lung was bound down by adhesions and the ribs were also rigid, a cavity would remain, which could only be closed by excising a portion of several ribs, so that the cut ends might fall inwards until they come in contact with the lungs and obliterated the cavity; hence in the young, simply draining the pleural cavity is generally sufficient for a cure, while in those who are older the above mentioned excision of several ribs must be performed. In the above case, however, the excision of a portion of a rib was not to close a cavity, but to keep the drainage tube from being pinched between two contiguous ribs, an inconvenience which the Doctor had experienced in another case. In regard to having irrigated the pleural cavity with sublimate solution, upon a previous occasion a hot solution 1 to 2000 was used with the result of causing toxic symptoms, diarrhœa, griping, sore mouth, salivation, etc., etc. In this case 1 to 5000 was the strength employed with perfect success.

Dr. J. W. Chambers did not think that simple drainage would in all cases cure traumatic empyema. He had drained in one idiopathic and in one traumatic empyema and both had died. They occurred in young men.

Dr. H. Clinton McSherry wanted to know the necessity for a posterior opening when an anterior one already existed.

Dr. R. Winslow, made the posterior opening in order to take advantage of gravity when the patient was on his back. He did not intend to say, as Dr. Chambers seems to have understood him, that empyema was a trivial trouble but he did think that the danger might be very much lessened by proper antiseptic precautions. He takes the thermometer as the index for removal of the dressings.

Dr. W. J. Jones then related a case of

CARDIAC DISPLACEMENT TO THE RIGHT SIDE.*

Dr. L. McLane Tiffany thought Dr. Jones' case the second of the kind reported in this state. The first was reported at the State Faculty by Dr. S. C. Chew.

Dr. E. G. Waters, said that Dr. Jones' case was of personal interest to him, for when a child, he had had a pleurisy, followed by empyema which in turn was followed by displacement of the heart to the right side. Paracentisis' was performed and after recovery from the pleuritic trouble the heart returned to its normal position.

A Collection of Skulls.—The Natural History Museum at Vienna has just been presented with 708 skulls collected through a series of years by Dr. Weissbach, who was for a long time director of the Austro-Hungarian hospital at Constantinople, and was a very distinguished anthropological investigator. Of the collection 195 are pure Turkish skulls, 131 Greek, 96 Servian or Croat, 48 Hungarian, 44 Armenian, 29 old Byzantine. There are also skulls of Maronites, Albanians, Koords, Asiatic Jews, &c.—*London Med. Times.*

*See page 244.

THE BALTIMORE ACADEMY OF MEDICINE.

STATED MEETING HELD JAN. 6, 1886.

Dr. J. J. Chisolm presented the following notes on

A PIECE OF IRIS LIVING IN THE VITREOUS CHAMBER.

G. T. S., æt. 59, six months ago, falling down a railroad enbankment, received an injury to the right eye. When seen by his family physician six hours after the accident, he was suffering intensely. The lids had already become very much swollen. Upon carefully separating them a wound was discovered at the upper edge of the cornea from which a thick splinter of wood was protruding. The removal of this bit of wood was accompanied by a bloody aqueous discharge, leaving, however, so much blood in the anterior chamber as to conceal the amount of injury done to the eye contents.

The treatment pursued was rest, cold applications, and the internal administration of anodynes. As the swelling subsided and the blood was absorbed, it was found that sight had been so materially impaired as to leave only perception of light. In time, however, the vision slowly improved till after three months large objects could be again recognized. In the mean time, the left good eye indicated some growing impairment of vision for distant objects and the spectacles heretofore worn with comfort, no longer permitted easy reading.

This growing defect in vision in the good eye, was supposed to be a sign of sympathetic complications, and for this reason the patient was sent to me from his distant home for surgical treatment.

I found the left good eye hyperopic v $\frac{15}{15}$ with a + $\frac{1}{20}$, his distant vision became $\frac{15}{15}$ even above normal, and he read brilliant type readily with a + $\frac{1}{8}$ lens. His spectacles were + $\frac{1}{12}$ which accounted for his discomfort. At first sight the injured right eye presented every appearance of a successful cataract extirpation.

The iridectomy was large, well shaped centrally located, and clean to the very ciliary border. The well formed artificial pupil was black with traces of capsular deposit as is seen after successful cataract operations. He could detect large objects and count fingers readily at four feet, the distance at which I was sitting from him.

In putting a + $\frac{1}{3}$ lens before his injured eye I was surprised to find v $\frac{15}{70}$, and with a + $\frac{1}{2}$ of $\frac{1}{8}$ lens he could make outwords in brilliant type.

He complained of something moving about in his eye, which seemed to wave before his sight. By oblique illumination I could see a whitish body in the vitreous. With ophthalmoscopic illumination the examination showed a healthy fundus and clear vitreous, so as to give a perfect retinal picture.

Hanging from the roof of the vitreous chamber at some little distance behind the thin, partial capsular film, was a flap of membrane apparently one line wide and two lines in length. It was rectangular in shape and of a yellowish white color. Upon its anterior surface could be clearly traced a vessel of same size, which starting at the base ran down through the whole length of the membrane, to the free extremity of the flap.

This piece of living tissue moved to and fro with the movements of the eyeball. This floating membrane in the vitreous, adhering to the upper anterior edge of the choroid, could be nothing else than the missing piece of iris.

The splinter of wood in entering the eye through the upper scleral border of the cornea, had torn the iris in two places from the pupiliary border to the ciliary region, in this way punching a piece out of it. This detached bit of iris had been pushed back into the vitreous chamber, carrying with it a portion of its ciliary body. It remained adherent to the ciliary body at one point by a broad base.

The lens must have been injured also at the time of the accident, because through its torn capsule the aqueous humor had been brought in contact with it, to its complete disappearance by absorption.

As there was a broad base to the flap with ample nourishing blood-vessels, the piece of displaced iris had continued to live. Although it had been bleached and all trace of pigment had disappeared from it, it was yet thick enough to show us translucency. Under ophthalmoscopic examination it showed boldly as a whitish yellow membrane against the healthy red reflex of the fundus. Curiously, the passage made by the splinter into the vitreous chamber had not been invaded by inflammatory deposits. The hyaline structures had taken on no pathological changes and therefore, excellent vision had been retained to this curiously injured eye.

Dr. J. Edwin Michael then related

AN UNUSUAL CASE OF GUNSHOT WOUND.

On Christmas night last, about 9 o'clock he was called to see a large, stout, well built German man, a saloon keeper by occupation, who had received a pistol wound, while engaged in quelling a disturbance in his establishment.

The ball came from a pistol of the "Bull Dog" pattern 38 calibre, and was shot from a distance of 12 to 14 feet in front of and a little to the patient's right.

Upon examining the patient it was seen that the point of entrance of the ball was at a spot almost if not directly over the apex beat of the heart.

Later measurements showed the exact location of the perforation to be 3 inches to the left of medium line, 1½ inches to right of left nipple line and ¾ of an inch below a line drawn transversely through the nipple. There was of course no probing. The patient was in a condition of extreme shock; stimulants were given and after a short while consciousness returned. Upon examination by physical signs, wound of the lower lobe of the left lung and hemorrhage into the pleural cavity of that side was diagnosed. It was also probable that there was a co-existing pneumothorax of small degree. About eleven o'clock, two hours after the accident, the patient began to complain of much general pain. He became quiet after a hypodermic of morphia and atropia, and con-

tinued comparatively easy for a time, when pain again began to be felt, which was again arrested by a repetition of the hypodermic injection.

At the end of 20 hours from the time of the accident the patient died.

The autopsy showed that the bullet had passed through the fifth rib, near its junction with the cartlage, through the pericardium, through the left ventricle, making in its passage an opening at its point of entrance and another at its point of exit, which two openings were connected by a furrow in the ventricular wall, ploughed up by the ball in its passage through the heart. After leaving the heart it had penetrated and passed through the lower lobe of the left lung, fractured the eleventh rib and imbeded itself in the soft tissues of the back about two inches to the left of the spinal column.

The Doctor thought it remarkable that such a ball should have passed through the heart without causing instant death. He had seen one other case in which the heart had been perforated by a 22 calibre ball. In this case, death was practically instantaneous.

In the case under consideration the wound was obliquely through the heart in such a way as to make valve like openings in the ventricular walls, similar to the openings in the bladder through which the ureters pass—this form of perforation, he thought prevented what would have been rapid hemorrhage into the pericardium, had the openings been made in a line, perpendicular to the plane at the point of entrance of the ball.

During life there was considerable hemorrhage but he did not think that it came directly from the heart, but was forced from the pleural cavity by the movements of the lung in respiration. The dressing consisted of cloths saturated in bichloride solution.

Dr. J. J. Chisolm said of course we had all heard of the rare case of perforation of the heart and retention of the bullet within its cavity until found there after death. He had seen cases of injury to the heart by bullets, but none of them had lived so long as 20 hours.

Dr. A. B. Arnold next read a most exhaustive paper on

CIRCUMCISION

in which he treated the subject from a moral as well as from a historical and surgical standpoint.

He protests against the practice not only because he considers it detrimental in robbing the glans of its natural protective covering and thus exposing to irritation those very sensitive pacinian bodies about the corona. The result of this exposure and consequent irritation, he thought led to habits of masturbation. From the religious point of view he considered it an entirely erroneous idea that a child born of a Hebrew mother was not a Hebrew until circumcision had been performed. It has recently been decided, he said, that a Jew can not be excluded from fellowship in a Jewish congregation because of the presence of a foreskin.

He described in detail the methods of operating pursued by physicians in the different countries, both civilized and barbarous.

In answer to the question, "had any hereditary shortening of the prepuce been observed in Hebrew children as a class?" he said he had noticed nothing different in the formation of the foreskin in them from that of other children.

Dr. James Carey Thomas thanked Dr. Arnold for the pleasure he had had in listening to a subject so ably treated.

Dr. Stanley Hall, who was present, was invited to make some remarks upon the subject. He said, after Dr. Arnold's paper, there was left but little for him to say—he had always been more or less in the dark on the subject, but had never had such a flood of light given him upon the topic, as had been afforded by Dr. Arnold's treatise. Some few years since he was in Vienna during a discussion upon the subject and it was there decided that circumcision was beneficial in lessening the erethic habit and that it was anticipating what nature would

herself do if left to her own course.

Dr. John R. Uhler said that possibly circumcision had its effect upon procreation by lessening the amount of surface tissue to be filled with blood and thus allowing a greater amount of blood to be supplied to the center of the organ. This would, he thought, have the effect of increasing the temperature of the body of the organ. Again he thought that possibly the reason for its having been first practiced in Eastern countries and especially in the tropics, was that the dry sandy atmosphere so potent in causing ophthalmia might have such an irritating effect by causing a gritty deposit beneath the foreskin.

Dr. J. Edwin Michael thanked Dr. Arnold for his paper. He had some time since read an article on the subject from a surgical standpoint. In his experience he had been frequently been called upon to remove the prepuce because of its inconvenience. As to affecting the sensitiveness and irritability of the glans he did not see that the operation made any difference whatever, for how very often do we see men with naturally exposed glans from an abnormally short prepuce. They present no greater degree of sensitiveness. He thought with some eminent authorities that the sensitiveness of the glans is increased by circumcision of long prepuce, the irritability decreased.

Dr. A. B. Arnold thinks too much importance has been attached to the part played by the organ in originating venereal desires. The brain, is the centre from which impulses arise. He thinks that when sexual impulses are observed in very young children, as is not rarely the case, that here it is not the brain, but some undue irritation to the corona of the glans. It is to protect against the possibility of such irritation that he advocates leaving the natural covering the prepuce, just as nature has made it.

Dr. John N. Mackenzie exhibited a portion of a growth coughed up from the larynx. The patient had suffered from dyspnœa caused by a growth almost completely filling the laryngeal cavity. Laryngoscopic examination revealed the growth to be composed of an oval mass composed of two lobes, divided by a shallow sulcus of what appeared to be fibrous tissue. The throat was so very irritable that local anæsthesia by the cocaine spray was necessary before any manipulation could be satisfactorily carried out. He removed a portion of the growth with the laryngeal forceps. This gave rise to such a degree of irritation that he was obliged to desist and postpone any further attempt at removal until the following day. On the following day dyspnœa was so great that tracheotomy became necessary. On the day succeeding she was attacked with a spell of coughing and threw off the portion of papilmatous growth here exhibited. Another attempt will be made to remove the growth with the forceps. Another case that he was examining for hoarseness revealed the presence of complete double uvula.

Illegitimacy in Lima.—The Peruvians seems to have a positive aversion to matrimony, if statistics prove anything. In the register of births for the month of August last, published in *El Monitor Mèdico*, of 392 children, 208 were illegitimate, 177 legitimate, and 7 doubtful. Of the negroes, 90 per cent. were illegitimate; of the pure-blooded Indians, 68 per cent.; of the mixed race, 60 per cent., and of the whites, less than 29 per cent. It is to be noted, however, that many couples live together as man and wife, and are faithful to each other, although they have not gone through the ceremony of a formal marriage, and their children are consequently recorded as illegitimate.—*Med. Record.*

Bequest for the Advancement of Science.—It is stated that about $25,000 has accumulated under a bequest of Mrs. Elizabeth Thompson, who desires the sum be appropriated "for the advancement and prosecution of scientific research in its broadest sense." Applications for grants out of this sum should be made to Dr. S. C. Minot, 25 Mt. Vernon St., Boston, Mass. The first appropriations will be made early in the present year.—*Journal of the Medical Association.*

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BALTIMORE, JANUARY 23, 1886.

Editorial.

MEDICAL SOCIETIES.—We are always pleased to note the growing usefulness and prosperity of a medical society, whether it be located in our own city or state, or in other localities. We believe that through the agencies of the various medical societies and associations more is being done to promote the interests of the profession and the cause of scientific progress than by any other work in which the organized efforts of the profession are engaged. To one who follows closely the literature of scientific medicine, the proceedings of the medical societies, as they appear in the many medical publications throughout the world, are full of interest and value. Whatever is of practical use or of original merit is almost sure to gain an introduction to professional attention through the medium of a society report, and, coming out in this way, is almost sure to bring with it an experience and a discussion which invest it with double its ordinary value. Society work is generally the seasoned fruit of large observation and experience; it has the wholesome flavor of the ripe juice which at once satisfies the appetite and taste of the professional palate. The profession can confidently turn to the reports of scientific organizations for its most reliable and trustworthy information upon all scientific subjects. To the medical journalists the well-prepared reports of medical societies offer the very best material from which to cull facts for the ready use of the reader. Recognizing then our obligations to the medical Society, we are in duty bound to labor for the advancement of this agency of professional co-operation. For some years past we have desired to see the medical societies of our city reach a position of usefulness which would place them in the front rank of scientific organizations. We have noted each year a growth in interest, in membership and in valuable work in several of our local societies. We are now glad to record the fact that a new life has been infused into the Academy of Medicine, and we believe into the Clinical Society, of this city by the publication of the excellent reports of the meetings of these two institutions. The Academy led the way by authorizing the reports of its meetings to be forwarded simultaneously to the leading medical journals of this country. The practical result of this move was shown in the fact that three medical *Weeklies* brought out the Academy's reports simultaneously, whilst the same report was published later in two medical *Monthlies*. The Clinical Society was not slow in following the movement inaugurated by the Academy. In future, we understand, the Clinical Society reports will be forwarded simultaneously to the leading journals. The Gynecological and Obstetrical Society has adopted a similar method in regard to its proceeding.

The result of this plan will, we think, be of decided value to the local society work of our city. We predict not only an improvement in the attendance upon the society meetings, but a decided gain in the quality and character of the work done. We suggest a similar course of action upon the part of the other local societies in this state.

Whilst our attention is directed to this subject we are pleased to note the fact that the New York Academy of Medicine, has recently liquidated its debt upon its valuable property on West Twenty-Third Street. The report of the Treasurer of the Academy, at the annual meeting held on the 7th of the present month, shows that the library fund now

amounts to $4,548,66; that the general permanent fund is $1,280,74; and that there is a balance of $137,80 of the fund for the liquidation of the mortgage. The library of the Academy now contains 27,000 bound volumes and 9,500 pamphlets. The donations to the library during the past year were 1,320 bound volumes, and 1,214 pamphlets.

This statement of the Academy's operations is to the highest degree creditable, and goes to show the brilliant results which may be secured by a medical organization when its officers and members are devoted to its wellfare and make an effort to promote its continued prosperity.

We present this picture of the New York Academy of Medicine with the hope that the profession in this city may feel stimulated to greater efforts in behalf of our medical organizations and of the Medical Library of our State Faculty.

Needed Medical Legislation in Maryland.—A prominent practitioner of medicine, residing in one of the counties of the state, has called our attention to the importance of attempting to secure a special Act of the Assembly, during its present session, making the claims of the physician "Preference Claims." Our correspondent calls our attention to the fact that the claim of the undertaker is a preference claim, in this State, whilst the physician has to come in as an ordinary creditor in the settlement of an estate. It is suggested that a bill may be gotten through the Legislature to correct this unjust discrimination. The matter is of sufficient importance to the profession of the State to receive attention at once, and we would suggest that a petition be drawn up with the endorsement of the state and local medical societies and be presented at once to the Legislature whilst in session. A committee appointed by the President of the State Faculty would be the most direct method of securing the object desired. We therefore call the attention of the President of the Medical and Chirurgical Faculty to this subject, and urge that it be given proper consideration. Our correspondent says: "If our State Faculty will take hold of this matter right away and get a bill through this Legislature it will make many friends."

Straw in Street Cars.—The *Medical News* in its issue of January 16, 1886, calls attention to the injurious effects which the use of straw or hay upon the floors of the street railway cars may have upon the health of the travelling public. It appears from the comment of the *News* that the use of straw for the purposes named is not confined to our own city, but is generally used by the street railway companies of Philadelphia. The custom is considered such a pernicious one that the Board of Health has condemned the practice as contravening the laws of health. A movement is also now on foot in the City Council of Philadelphia to compel by ordinance the abandonment of the practice, which is far from being cleanly and affording comfort, and certainly cannot fail to do serious harm in propagating diseases.

It seems to us the subject is one entitled to careful consideration at this season of the year, and we should be glad to see the Health Officers of our city giving it proper attention. In riding in the cars of some of our street railway lines our attention has time and again been arrested by the unsanitary condition of the floors of many of the cars in daily use. It is not uncommon to observe mud, sputa and other debris from careless passengers clogging the recesses in the floor pads and mats which give forth an odor far from being agreeable or healthful. Whilst we admit the difficulties which arise during such a season as the present in preserving cleanliness and ventilation in street cars, we think the sanitary condition of these public conveyances is entitled to an occasional inspection and criticism by our Health Officers. If it is not possible to secure better protection and comfort by appealing to the managers of the different railway lines, we would suggest a movement to bring the matter before the City Council.

Miscellany.

Opium-Poison Through Mother's Milk.—William T. Evans, M. D. and C.M. Edin., London, writes to the *British Medical Journal*, December 19th, 1885: "On November 17th, I attended T., in her eighth confinement, which was natural, although rather tedious in its first stage. She was delivered of a fine healthy female child about 1.30 P. M. I left her a drachm of liquor opii sedativus, to be taken in four doses, at intervals of four or five hours, if required, for the after pains. On visiting my patient next morning, I found she had had no sleep, on account of the severity of the after-pains; I therefore sent her six doses, of twenty minims each, of liquor opii, to be taken as before. (I may say that this patient had, on former occasions, suffered in an unusual degree from these pains.) On the 19th, I found on my visit, that she had about three hours' sleep, but that the after pains were still troubling her about every fifteen minutes. I therefore repeated the medicine I had ordered the day before. On the 20th, I found that she had had more sleep than on the previous night, had finished the medicine, but was not at all drowsy, nor under the influence of opium in any way, except the relief it had afforded her from her pains. The milk came into the breast during the night, and at 4 A. M. the child was put to the breast, and sucked well. It took it again about 7 A. M., but not quite so freely as before. Up to this time, the infant had been fed on milk-and-water and gruel. At my visit, it appeared to be comfortably asleep, so much so, that the nurse had not washed it. At 2 P. M., I was sent for, with the request that I would go at once. I did so, and found the infant very drowsy. On examination, the pupils were contracted almost to a pin's head. The respiration was slow and tranquil. The countenance wore a placid expression, like a child in a natural sleep, and was rather pale. The skin was moist with perspiration. I roused the child with difficulty, but it relapsed at once into its former sleepy state. From these symptoms, I diagnosed the case as one of opium poisoning, and ordered the nurse not to lay the child down, but to constantly rouse it, and give it frequently strong coffee (with milk) as a stimulant. I also cautioned her not to put the child again to the breast. A few hours later, as there was no improvement, I ordered liquor ammoniæ to be dropped on a pocket-handkerchief and applied to the nostrils. I was sent for about midnight, and, on arriving, found the child had ceased breathing. I performed artificial respiration for about half an hour, but without avail; the child was dead.

At the inquest, the coroner informed me that he never met with a similar case; therefore, I thought it would be interesting to record it as a case of opium-poisoning communicated to the infant through the medium of the mother's milk, and at the same time to put medical men on their guard against allowing an infant to take the breast where it is necessary to give large and continuous doses of opium to the mother.

Acute Pleurisy.—Professor Da Costa often orders—

Tinct. aconiti rad, - - min xxx;
Potassii acetatis, - - - oz ss;
Morphia Sulphatis, - - - gr ss;
Liq. potassii citratis, - - - oz ij;
Syrup tolu, - - - - - - - oz j;
M. Sig.—Two teaspoonfuls every three hours.

In chronic pleurisy, Prof. Da Costa has obtained excellent results from—

Potassii iodidii, - - - - - dr ij;
Tinct. digitalis - - - - - dr ij;
Tinct. opii camp., - - - - oz iss;
Aqua, - - - - - - - - - oz ss;
M. Sig.—One teaspoonful four times a day.—*Med. Bul.*

In a paper "On the Relation of Lithæmia, Oxaluria and Phosphaturia to Nervous Symptoms," published in the *Medical Record*, of January 16, 1886, the author, Dr. C. L. Dana sums up with the following conclusions.

1. There is no such thing as lithæmic or uric acid diathesis, or as an oxalic acid or phosphatic diathesis.

2. There are, however, morbid condi-

tions of the nervous system which are associated with excessive acidity of the urine and excess of uric acid in the urine. The morbid nervous symptoms in these cases are those of gastric neurasthenia, lighter forms of spinal irritation, great nervous irritability, vertigo, headaches, bad sleep, hypochondriasis, etc.

3. The "lithæmic state" is one that is allied to gout and rheumatism, rather than identical with either.

4. The lithæmic state in question, associated with nervous symptoms, is generally brought on by some overstrain or draining of the nervous system, or by some chronic poisoning of it, as by malaria or lead. It is probably a trophic or metabolic neurosis comparable to diabetes.

5. Oxaluria is generally only a form or indication of lithæmia. When oxalate of lime occurs in abundance with deposits of earthy salts, it has no clinical significance.

6. Phosphaturia, or an excessive deposit of earthy and alkaline phosphates in the urine may be only apparent and due to deficient acidity of the urine from excess of vegetables or fruits in the diet. But an excessive discharge of phosphates may accompany conditions of functional nervous depression and irritation. It indicates in these cases a disturbance of digestion, due perhaps to some perversion of the innervation of the digestive organs. If kept up, the loss of phosphates and undue alkalinity of the blood may react upon the nervous system, but in the vast majority of cases phosphaturia is only an evidence of indigestion.

7. It is of great importance for purposes of diagnosis and treatment of chronic functional nervous disorders that a careful study of the acidity and alkalinity of the urine be made, and that the proportions of urates and phosphates discharged be estimated.

Miss Alcott remarked during a trip on an ocean steamer: "They name ships Asia, Persia, and Scotia. I wonder it doesn't occur to somebody to name one Nau-sea."—*Med. Record.*

Medical Items.

The Philadelphia County Medical Society, one of the largest and most influential of the local medical societies of this country, at its annual meeting recently held, elected delegates to the next annual meeting of the American Medical Association, who are opposed to the action of the Association in reference to the method adopted at New Orleans in respect to the organization of the International Medical Congress. Two tickets were placed in the field, the one supporting the Association being defeated. The vote stood 169 to 36. This gives a very fair statement of the status of the profession in Philadelphia in reference to the New Orleans work of re-organizing the Congress. As goes Philadelphia so goes the whole country.

Dr. S. Weir Mitchell, has been elected President of College of Physicians of Philadelphia, for the ensuing year, and Dr. R. J. Levis has been elected President of the Philadelphia County Medical Society.

The Philadelphia *Medical News* announces the organization of an anti-vaccination society in that city, which has elected for its president a notorious quack, who lives by preying on the fears and credility of those unfortunate youths who are afflicted with sexual hyperchondriasis.

The *Medical Record* credits the *Medical Age* with a statement that the largest calculus ever successfully removed from the bladder was by Dr. Dunlap, of Springfield, Ohio. It weighed over twenty ounces.

The Hospital Sunday Collection in New York City, amounted at last accounts to 35,381,07.

The Health Officer of New York City, is paid by fees, and gets, it is believed, from $50,000 to $75,000 yearly. The *Medical Record* suggests that it is very desirable, from an economic point of view, that there should be some change in the present condition of things.

Original Articles.

THE EFFECTS OF A HEAVY DOSE OF SALICYLATE OF SODIUM.

BY JULIAN J. CHISOLM, M. D.,

Professor of Eye and Ear Surgery in the University of Maryland, and Surgeon in Charge of the Presbyterian Eye and Ear Charity Hospital of Baltimore.

For many years I have found the salicylate of sodium a most active remedy for the prompt relief of painful attacks of iritis, whether from specific or rheumatic causes. It will subdue pain and remove congestions of the eye tissues more rapidly than any other remedy that I have tried. In the dose of from 25 to 30 grains, given every four hours, the beneficial effects are often magical. Patients who could not sleep for eye pains, notwithstanding leeching, the local use of atropia, and the administration of iodide of potash and mercury with opium, have obtained complete relief before a half-dozen doses of the sodium powders have been taken. The eye pain and eye congestions vanish, and convalescence seems to be well established after a very few doses of the salicylate. The head effects are at times very uncomfortable when the remedy is pushed for any length of time. The ears buzz as if from very large doses of quinine, and an irritable brain may be tormented with all the horrors of delirium tremens. These very annoying effects will very soon pass off when the administration of the medicine is suspended.

Recently one of my patients took a very much larger dose than was designed. A prescription calling for ʒiv of the salicylate of sodium to be divided into 10 powders, making a dose of 24 grains, was put up by the druggist as ℥iv making each powder contain 192 grains of the salt. Very fortunately this enormous dose did no serious harm, although the patient was very much prostrated by it for a short period.

R. K. T., aged 32, had suffered for several days with a very painful left eye. There was much ciliary and conjunctival injection, with some haziness of the cornea. The iris was torpid, pupil acting slowly, but still dilating evenly under a 4 gr. solution of the sulphate of atropia. The patient had suffered severely at times from rheumatism, and the eye attack seemingly was of a rheumatic nature. The severity of the eye pain had kept him from sleeping and had made him very miserable. I prescribed for him 10 powders of 24 grains each of salicylate of sodium, each one to be taken every 4 hours, dissolved in a half-tumbler of water. The druggist made his powders to contain each 192 grains, by reading the ʒ sign for ℥. The first powder was taken in all confidence by the patient at 2 p. m. It was not long before he experienced most uncomfortable sensations. His head felt full and his ears commenced to buzz. He became weak, was nauseated, and had to go to bed. At six o'clock, four hours after taking the dose, diarrhœa set in, and one hour later he vomited. The night was passed in such miserable wretchedness, that a second powder was not administered. The next day the brother of my patient came to explain to me the effects which the powder had produced and brought me one of them for examination. He reported the patient now relieved of nausea and diarrhœa, but too weak to get out of bed. The eye no longer gave him pain. He did not know at what time relief came, as his other more pressing annoyances were all absorbing. He got out, and to my office in 3 days after the dose was taken. All pain and injection of the eye had disappeared. The cloudy vision had nearly gone, and no further eye treatment seemed necessary. The case is instructive in many ways and offers comfort to many practitioners who prescribe ℈i doses of the salicylate of sodium with hesitation, fearing bad effects from what they believe to be so large a dose. This dose of 192 grains, dissolved in a half-tumbler of water, had caused diarrhœa before vomiting, which did not take place until 5 hours after the medicine had been administered. We might therefore fairly believe that after five hours not much of the drug remained in the stomach to be ejected, and that the

effects produced represent the degree of depression which so large a dose can occasion. The symptoms could not have been alarming, as it was not thought necessary to call upon me for advice till the next day, when only a general debility remained.

HOW SHALL WE USE ANTIPYRETICS* ?

BY JOSEPH T. SMITH, M. D.,

Visiting Physician to Bay View Asylum.

This is a question which has lately excited a great deal of attention and many have written upon the subject, but it is one which has not yet been fully answered, it is one concerning which much difference of opinion still prevails; this being the case we have ventured to return our answer to it to-night and endeavor if possible to elicit that of others. No one subject, in the whole range of medicine, (I use the word in its strict sense) has from the beginning excited so much attention and interest and called for more earnest thought and study than fever, its causes, progress and results. We stand to-day by the bed-side of our fever patients, as did our fathers before us, saying what is all this tumult, whence comes it, what shall be done with it and what footprints will it leave behind? Progress has indeed been made in our knowledge of fever since the days of our forefathers and notably in the direction indicated by the title of this paper, namely; remedies for the reduction of the temperature always present; but much is still to be learned even here and though we have the power at hand, shall we use it, how and under what circumstances shall we use these potent agents and compel, at least for a time, a return of the normal or more nearly normal temperature. In our study of fever, up to the present time we have not succeeded in getting very far beyond the etymological significance of the word, it is a burning, an increase of temperature, this is its constant accompaniment; but it is more; how much more still remains to be determined, for were that all, fevers as a class need not exist, we have the means at command to reduce the fire, to keep down the temperature. All of us know how easy a thing it is very many times to reduce the temperature and at the same time we know how equally difficult it is to keep it at the normal. By vigorous means, we cause the thermometer to register 98° or 100° in the mouth, but withdraw for one moment the restraining hand and how soon the temperature will rise; our efforts have restrained, not overcome.

In a simple fever from an unknown cause, shall we resort to the restraining influence of antipyretics? The limits of this paper forbid the discussion of the relative value of quinine, antipyrin, kairin, resorcin, quinoline, cold, etc., we must leave these for each practitioner to value for himself, we can do no more than refer to them as a class. In a case of recent fever, supposing no positive diagnosis to have been made, Professor Nothnagel of Vienna, says: "I cannot help protesting against an abuse, I can call it by no other name, an abuse which has generally extended in practice, namely the tendency to treat a fever *a tant-prix*. When a practitioner is called to a patient who sickened yesterday, and who to-day has a temperature of 101°, and it is not possible to make a positive diagnosis, as no local affection is as yet discoverable, treatment consists in administering quinine, or some other antipyretic * * * * To return again to the point from which I started, I maintain that it is an abuse to administer antipyrectic agents, especially quinine in temperatures of 102° and 103° on the very first day of treatment, when one has yet no definite idea of the developement which the disease process will take." "In general we may say that a temperature which does not exceed 104° does not injure the patient." The same author remarks in another place. Thus it has always seemed to me, and I am glad to be so well endorsed, that the expectant plan in its most rigid form was the true plan in all such cases; it has been my practice to watch the fever of

*Read before the Baltimore Medical Association, January 25th, 1886.

course and except to keep up the activity of skin and kidneys by means of mild diaphoretics and diuretics, to refrain from meddling until I could strike at something more than a mere symptom. In the case of a lady whom I was called to see a few weeks ago, who was attacked with a chill, followed by fever, I could for two days find no special cause for the fever, I administered a mild diaphoretic and waited, soon symptoms pointed to acute congestion of the stomach to which I then gave my sole attention, letting the temperature alone, as at no time did it exceed 103°. The case did well in all respects and I have every reason to think that had I used quinine, antipyrin, or other drugs in quantities sufficient to markedly reduce the temperature they would have been a source of irritation to the stomach and as the result showed would have done no good. The elevation of temperature was secondary to the stomach trouble and I believe in all such cases it should be looked upon as a symptom only and should be treated as any other.

We have few drugs of such value as quinine when rightly used and few I am well convinced which are more abused in just such cases as I referred to, the temptation is great to at once combat the fever and quinine is the best known and most easily administered remedy. I am glad to be able to quote from Professor Nothnagel in this connection. He says, speaking of the treatment of fevers. "In order to do no harm, one prescribes a small dose, but one does give quinine thereby suggesting that the fever must be in some way removed. I have received the impression during the last six years or so, that the employment of quinine has become a reflex phenomenon. We have begun to mancipate ourselves from the opinions which were general fifteen or twenty years ago. I would suggest that the fear of a temperature of 102.5° owes its origin to the scientific employment of the antipyretic method introduced by Liebermeister according to the method of Brandt, which in itself is an excellent procedure and which has added much to our resources. As the treatment by cold baths is attended with some difficulty and patients have some aversion to it, one began to employ quinine and since then this drug has been given on a much larger scale than digitalis, nitre and nitrate of soda were employed in earlier times. The two latter have now fallen into disuse. I cherish the hope and the conviction that this false and erroneous employment of quinine will also in time be discontinued."

It is true the temperature may reach a high point 105° or 106° and by its continuance or its manifest injurious effect upon the system, as shown by delirium, exhaustion, etc., demand attention, but even then the effort should be, rather to regulate than to rapidly reduce it, at the same time keeping a watchful eye to discover what the cause of the disturbance is. It happens many times we are called upon to see a child with a high temperature, and except, possibly a slight headache, furred tongue or sick stomach, we find nothing else; we know absolutely nothing as to what the trouble is; how much better it is to wait and watch developments, than to commence with quinine or other antipyrectics simply to reduce the temperature. In such cases the fever may and often does depart as mysteriously as it came, leaving no trace behind or it may be the forerunner of a serious disease; in the one case nothing is needed, with a little assistance it may be, nature will take care of herself; in the other we need to treat the disease, not the fever, for though we may keep the temperature down, the disease will run its course and as the authority quoted above says: "I maintain that we do not shorten the duration of the course of an acute fever, even by a single day when we have succeeded in diminishing the temperature; we even know there are typhoid processes which run a non-febrile course without any therapeutic treatment and in which, nevertheless, death results."

Indeed I know of no class of cases which show how little real harm is done by fever alone than in those just spoken of—those namely in which a young child will have a high temperature for a couple of days or more, and then all at once it will dis-

appear, leaving no bad effects behind, and that in spite of the fact that you have done nothing but wait and watch. Let us turn now in the second place to that class of fevers, happily in the majority, in which a positive diagnosis has been made; here the fever exists, but we have a something more; we know that the fever is not all—it is the consequence of or accompanies causes originating either within or without the body, and these abolished, the fever ceases. This, it seems to me, should guide us in the use of antipyretics; the fever is not to be treated for itself alone, unless it reaches a dangerously high point, and even then it should be controlled without our losing sight of the disease of which it is but one of the symptoms.

We should deal with fever as a symptom only; just as we treat the diarrhœa or hemorrhage in typhoid fever for instance; here we watch and keep them in check when danger threatens, we look upon them not as the disease, but as its results. In the same light should we regard fever. We should not then at once upon the appearance of peril call in the aid of our antipyretics, but wait, battle with the disease, and only when from its great increase or manifestly injurious effect it threatens danger should we control it, looking upon it as an adjunct which may kill if not mitigated. A high temperature in very many cases is no small thing; it is always to be looked upon with apprehension, but just as we look upon intestinal hemorrhage in typhoid fever, for instance; here a slight discharge of blood, while not alarming, puts us upon the watch, and a severe hemorrhage causes us to bring our strongest remedies to bear upon it. A high temperature is to be watched and controlled, and it is a symptom that often demands the most rigorous measures for its relief. I, therefore, do not wish to be understood as speaking lightly of high temperature, but I do say that it is to be looked upon as a symptom only. Who ever cut short by as much as a single day an attack of typhoid fever by keeping down the temperature only?

Still further, too much meddling with the temperature and an over anxiety to keep it down to the normal in many cases may I am sure do harm in that it removes from us a very important guide as to the progress of the disease. All know how valuable the morning and evening temperature is in certain diseases as showing progression or retrogression, and without this to indicate the condition of our patient we would be like the mariner without his compass.

In some forms of fever indeed, any so-called antipyretics have little or no effect, the high temperature continues in spite of them and patients recover. Thus in speaking of relapsing fever, Dr. Wm. Pepper says: "In conclusion it may be said that the evidence shows positively that quinine possesses no specific influence whatever upon relapsing fever; that in only occasional cases, if at all, will even enormous doses given during the intermission postpone or modify the subsequent relapse, and it is not effective in reducing the temperature." He finds the same true of other antiperiodics, and says: "One chief reason of the failures of antipyretics in relapsing fever is to be found in the existence of widespread irritative leasions of the glandular and mucous tissues, which combine with the specific blood changes in causing and maintaining the high temperature. Opium, or morphia, must indeed be regarded as the basis of the rational treatment of relapsing fevers." No stronger argument it seems to me is needed to show the uselessness of treating fever for its own sake, and the value of seeking the cause, so that the exciting cause having been done away with the fever itself will cease.

Typhoid and scarlet fevers are good illustrations of the truth of what has just been said, in mild cases but little attention, beyond that needed to watch the progress of the disease, need be bestowed upon the temperature; it is only when it assumes alarming proportions that we put forth efforts to control it, and just in proportion to its severity. But it is needless to go over the list of fevers in detail, and I will close with a reiteration of the importance of regarding a high temperature as a symptom only, and not as the disease.

Society Reports.

BALTIMORE GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY.

STATED MEETING HELD JAN. 12, 1886.

The President, GEORGE W. MILTENBERGER, M. D., in the chair. WM. E. MOSELY, M. D., Secretary.

Dr. L. E. Neale read a paper entitled,

TWO CASES OF DYSTOCIA.*

DISCUSSION.

Dr. H. P. C. Wilson said he had nothing to offer in regard to Dr. Neale's paper except words of commendation, and he was very ready to accept the teachings advanced. In his own practice, in cases of presentation of the breech demanding interference, he always brings down a foot. If the breech is engaged in the superior strait he pushes it up into the uterus and brings a foot down, even if it is at the fundus uteri. He never exerts traction in the groin either with his finger or the blunt hook, and never uses forceps in such cases. With greater experience, turning grows more and more in his favor.

He referred to the confinement of the wife of a friend in Copenhagen, in which case the head presented; after prolonged effort and failure with forceps, the child was removed by embryotomy. He felt certain from the account he received, that, had turning been resorted to early there would have been very fair prospects of saving the life of the child.

Dr. B. B. Browne had succeeded twice lately in delivering the child with Tarnier's forceps in difficult breech presentations, when the membranes had been ruptured several hours, the vagina hot and dry and the breech firmly fixed in the superior strait. In a similar condition, several years ago, he had applied Elliot's forceps, but it slipped and failed to deliver the impacted breech. In all cases where the membranes are unruptured or where the breech is not firmly wedged in the pelvis, he would prefer bringing down the feet rather than using forceps.

In reply to a question Dr. Browne said he applied the forceps in these cases to the sides of the pelvis of the mother and without reference to the portion of breech upon which the blades would press.

Dr. Neale, in reply to a question, said, that in the first case reported, the blades of the forceps clasped the child over its hips. He thought, however, that the forceps would have a better hold if one blade was over the sacrum and the other over the anterior aspect of the opposite thigh, which is the method recommended by Dr. Lusk.

Dr. Thomas Opie highly approved of the teachings set forth in Dr. Neale's paper. .In practice he always made due effort to bring down *both* legs in decomposing the impacted breech or in turning the child. The hand grasping both knees or one knee or thigh, has always a more secure hold than by a foot or even both feet and the traction acts more directly and efficiently on the body.

Dr. Neale wished to say, in regard to Dr. Wilson's remark that he "always went for a foot" in breech cases requiring interference, that he believed there were many cases in which it was practically impossible to bring a foot down, as when the breech already occupied the pelvic cavity and could not be pushed up into the uterus so as to free a foot.

Dr. Thomas Opie read the history of three cases.

CASE I.—PREGNANCY COMPLICATED WITH LARYNGEAL PHTHISIS WITH SUBSEQUENT CONFINEMENT.

Mrs. M., age 30, primipara, had suffered from severe pneumonia three months prior to conception. A brother had died of phthisis at about her age. Laryngeal phthisis set in about the middle of pregnancy. At the expiration of her eighth month, there was great dyspnœa, pulse 120, respiration 30, temperature 102, and severe pain in the lower lobe of the right lung. This latter

*See MARYLAND MEDICAL JOURNAL, January 23d, 1885. Page 237.

symptom was imputed to mechanical causes, from the right lateral obliquity of the uterus. So great was the embarrassment of respiration and pain, that the idea of artificially inducing labor was seriously entertained. On the 19th, labor pains set in at 7 A. M. The dilating stage lasted five hours. At 1 A. M. the head was low in the pelvis, the pulse 160, respirations 60, sweating profuse, countenance indicative of great fatigue. The childs movements and pulse showed it to be well and strong. The forceps were applied and the child delivered in excellent condition. There was no laceration of the perineum, and the uterus contracted well. There was no relief to the function of respiration. The pulse continued its same rapid stroke, the dyspnœa was quite as great as ever, and death closed the scene as if from the accumulation of carbonic acid in the blood. The child was well developed and vigorous, having drained the mother for its own support. I presume there are few supporters at present of the theory that pregnancy retards phthisis by derivation and revulsion. This case seemed one in which the disease was aggravated if not developed under the trials of gestation.

CASE II.—A UNIQUE PRESENTATION.

Mrs. R. H., was delivered by me, in 1884, of a still born child at full term. The os was dilated by Taylor's narrow blade forceps, and the traction rod forceps applied above the superior strait. The head not advancing under reasonable force, and the child being dead, cranioclasty was performed. Following her confinement she had severe metritis. In twelve months from her first labor, I was called to her in premature delivery of a dead child at 8 months. The presentation was in my experience unique. Both hands and one foot were presenting in the os, above the superior strait, and the funis was prolapsed into the vagina. Inspection and palpation showed the shape of the abdomen as well as the contour of the uterus to be normal. The child was doubled upon its abdominal plane, its dorsal region corresponded with the fundus uteri, the head was on the shelf of the right iliac fossa, the ulnar surfaces of the hands, and the calcis of the presenting foot looked towards the left iliac region. Chloroform was given to complete anæsthesia. The missing foot was found, and this and its fellow, seized with my right hand only partially introduced into the cavity of the uterus. The left hand assisted in the act of version through the abdominal wall, as in the combined, or bipolar method, introduced by Braxton Hicks. The membranes had been ruptured for three days, but no serious difficulty was realized in turning the child. In view of the softened and yielding state of the child's tissues, it became most important that traction should have been made with both legs. The atony of the uterine walls fully compensated in turning for the disadvantage from the loss of expulsive power. When the head was extracted the occiput was pushed up, the chin was flexed and simultaneously pressure was made by an assistant. The position as at first diagnosticated, could only have occurred in a dead child. I think it was originally a right occipito-iliac position. The child having lost its resiliency, first assumed, under the uterine contractions, an oblique position; and nature, unequal to the task of delivery by the head, began the work of self turning by the feet. The patient made rapid convalescence uninterrupted by a single abnormal symptom.

CASE III.—DIAGNOSIS OF TWINS. A DOUBLE BATTLE-DOOR PLACENTA.

Mrs. B., primipara, was delivered Jan. 5th, of twin girls, at the end of the eighth month of pregnancy. Was called a month before labor to examine, what proved to be, a hernia in left inguinal region. An opportunity was given for a thorough exploration of the abdominal tumor. Inspection and measurement showed the transverse diameter of the uterine globe to be as long as the vertical. Auscultation revealed on the extreme right a heart sound, and a loud placental murmur at a corres-

ponding site on the left side. A number of small fœtal parts, not clearly distinguishable were found, too many and some of them too far removed from the fœtus on the right side to be imputed to that child. Twins were predicted. The placental souffle likely masked the heart sounds of the child on the left side. The first child was born after a tedious labor of twelve hours, the waters breaking in advance. The second child was born one hour later. The membranes broke when the head was dilating the vulva.

The placentæ were firmly united and the cords were inserted very near the ridge where they seemed welded together. They were so close together and so near the line of union, as to give the appearance of a double battle-door placenta. Each fœtus had its own amnion and chorion, but there was a common decidua. The close union of the placentæ on the left side of the uterus, coupled with the fact, that both children were of the same sex, makes it highly probable that the two ova were deposited in the same fold of the decidua vera, that they came from the left ovary and were from the same Graaffian vesicle.

Dr. John Morris reported the following case of

LABOR COMPLICATED BY PLACENTA PRÆVIA AND AN INTRAMURAL FIBROID TUMOR.

On Sunday evening, January 3d, I was hurriedly summoned by Dr. William N. Hill, of this city to a case of labor. The patient was in charge of Dr. Hill and Dr. J. J. Gross. Dr. Hill furnishes the following history of the case: "Dr. Gross first saw the woman last March, which corresponds with the date of her first month of pregnancy. He discovered a tumor in the left side, which caused the patient to complain of pain, especially while standing. After rest for a couple of weeks, warm applications, the administration of narcotics and iodide of potassium, she became convalescent and progressed favorably during the remainder of her pregnancy. On Saturday, January 2d, at 9 P. M. she was delivered, by a midwife, of a living child. Dr. Gross was called in at midnight and found the woman flooding from adherent placenta. He tamponed, gave ergot, and the hæmorrhage ceased. Owing to the contraction of the os and the partial projecting of the placenta, a full examination of the interior of the womb was an impossibility, although the size and appearance of the abdomen were such as to lead Dr. Gross to the belief that there was a second child present."

"At 7 A. M., Sunday, the os was closed firmly on the projecting placenta; no hæmorrhage, ergot continued. I was called to assist Dr Gross at 4 P. M. on Sunday, and found the os dilated sufficiently to admit the hand partially. Portions of placenta, not adherent, taken away. Appearance of womb as to size and irregularity remained unchanged although examination by touch revealed no presenting part or membranes. Pains slight, and at long intervals. The progress of the case afterwards you, yourself observed."

I saw the woman on Sunday evening, at 6 o'clock, twenty-one hours after the delivery of the child. She was a respectable, intelligent, colored woman over 40 years of age. She was quite feeble and greatly exhausted from pain, loss of sleep, and anxiety of mind, as well as the previous hæmorrhage. She was, however, very patient and hopeful. Fortunately the hæmorrhage had ceased. I first examined the child, as I was very doubtful, from the history given me, of the presence of a second one in the uterus. The baby was a healthy, wholesome little thing, and weighed about 7 lbs. It was slightly larger than twin children usually are. I next made an examination of the abdomen. I found a tumor or hard mass nearly the size of a small child. It was solid and unyielding to the touch. It was not symmetrical in shape, and lay chiefly on the left side of the abdomen. This tumor presented no angles or projecting points such as you would be likely to find in the case of a twin child. I then proceeded to make an examination, per vaginam, and discovered the os partly closed, and the placenta adherent on the

left side of the cervix and anterior portion of the womb. I found great difficulty in passing the hand, and consequently determined to administer an anesthetic. She came readily under the influence of the chloroform; I introduced my hand, broke up the attachments of the placenta, and removed it *en masse*. I then made an exploration of the uterus and found as I anticipated, a large tumor. It was an intra-mural fibroid, and filled up the posterior and lateral wall of the uterus. It terminated in a small pedicle, or tumor the size of a walnut which covered by the mucous membrane projected into the uterus. The continued use of ergot had produced violent contractions, and pressed the tumor tensely upon the placenta, thus deceiving the gentlemen in attendance as to the true character of the mass felt by abdominal examination.

This case presents some very singular features. The fact that a woman over 40 years of age, suffering from a fibroid tumor, filling up the greater portion of uterus is in itself, I think, an unusual circumstance. The attachment of the placenta to the cervix thus occasioning a partial placenta prævia was, no doubt, due to the law of selection inasmuch as the fundus did not afford a proper nutrient matrix for the support of the child. I would here remark (*en passant*) that the woman had not been pregnant for twelve years. Her pregnancy in this instance was no doubt due to the accident of the ovum, which came possibly from the left ovary, finding a nidus in the healthy cervix. The case taken altogether is a profitable one and may possibly prove of service to all engaged in it. I had not met a similar one in an experience of 40 years.

Dr. B. B. Browne remarked that about 10 years ago he had had a somewhat similar experience, the patient also being a colored woman. He was called to a case, which had been attended by a midwife, about twelve hours after the delivery of one child, to deliver the other, which the midwife said was fast and could not come away. Upon examination a sub-peritoneal tumor as large as a fœtal head at full term was found. The tumor had attained this large size during the period of pregnancy. With involution of the uterus the tumor decreased rapidly in size and at the end of six weeks could scarcely be detected This case was reported in the *American Journal of Obstetrics* vol. x p. 39.

Dr. Morris asked Dr. Miltenberger's opinion as to the theory advanced in the paper, that the ovum had by a law of selection attached itself to the cervix, not finding a proper nutrient *nidus* in the body of the uterus.

Dr. Miltenberger thought the theory a very plausible one.

Dr. T. A. Ashby asked Dr. Morris whether menstruation had occurred during pregnancy in the case which he had related. Several cases had been reported in journal literature, where menstruation had continued during pregnancy, and the explanation offered was based upon the discovery of polypi and sub-mucous fibroids in the uterus. In the classical case reported some years ago by Dr. L. M. Yale menstruation was observed in a pregnant woman, and upon examination a very small polypus was found and removed, and hæmorrhage did not again occur during the pregnancy. Dr. Ashby was of the opinion that the explanation offered by Dr. Morris to account for the position of the placenta was a most rational one. The presence of the tumor had no doubt prevented the ovum from becoming engrafted upon the mucous membrane covering it, and as the tissues about the cervix were in a healthy condition a favorable site was offered for the development of the decidua and the growth of the ovum.

The Doctor then related the following history of a case which he had attended about a year ago. He was first called to see the patient during labor and learned that she was over five months advanced in pregnancy. For two weeks she had been losing large quantities of blood, but this circumstance had not attracted serious attention until severe labor pains set in. Upon examination he found the placenta firmly attached to the right side of the cervix, but a large portion which lapped over the internal

os had become detached. Hæmorrhage had resulted from this detachment, and the copious loss of blood had destroyed the life of the fœtus, which had evidently been dead for several days. The breech presented and, after some delay in dilating the cervix, delivery took place. The placenta being firmly adherent was detached with some difficulty. The patient made an uninterrupted recovery. Dr. Ashby considered that the occurrence of the abortion had proven a conservative process, as the full development of the child would doubtless have led to more serious complications. In this case there was no evidence of a fibroid tumor, but impregnation had followed pretty closely upon the birth of a child which may have accounted for the occurrence of a placenta previa.

Dr. Miltenberger said he thought that the prescence of an intramural fibroid would not, as a rule, cause hæmorrhage during pregnancy, although polypi are very apt to do so.

Dr. Browne asked Dr. Miltenburger if it was not his experience that fibroid tumors increased very rapidly during pregnancy.

Dr. Miltenberger replied that, at the moment, he remembered three cases of pregnancy complicated by fibroid tumors. In two of these there was marked increase in the size of the growth during gestation and rapid disappearance after confinement. Both occurred in young women.

Dr. W. P. Chunn thought that hæmorrhage might be caused by the unequal contraction of different portions of the uterus, due to the presence of the tumor, which might also, to some extent, prevent the expulsion of the placenta. Dr. Emmet had related a case in which alarming hæmorrhage followed the extraction of a sub-mucous fibroid, and was only checked after a second tumor, which was found in the parenchyma, was removed.

Dr. Robert T. Wilson referred to a patient of his who told him that the only time she menstruated or had any bloody discharge from her uterus was during pregnancy, but that during that period the flow appeared regularly each month, ceasing after labor had taken place. His patient was a white woman and had no fibroid tumor.

Dr. Morris believed that hæmorrhages during pregnancy did not result from intra-mural fibroids. As regards the prognosis in these cases, he felt safe in telling their friends that the tumor would disappear.

Dr. Browne remarked that the existence of fibroid tumors in the uterus was a recognized cause of sterility, but when pregnancy does occur in such cases, the tumors increase rapidly in size with the development of the uterus. After delivery, with involution of the uterus, the growths quickly diminish in size and frequently disappear altogether.

Dr. Neale referred to two cases, the histories of which he had read before the Medical and Chirurgical Faculty of Maryland.

Case 1.—Mrs. A. P., æt. 28, was delivered of her fourth child after a perfectly normal and easy labor. A teaspoonful of fluid extract of ergot was given post-partum, but a considerable bloody discharge with some after pains continued for twelve hours when the patient expelled from her uterus a fibroid tumor which the Doctor preserved. Its presence had not been suspected.

Case II.—Mrs. M., American, æt. 20, was delivered with forceps after a difficult and tedious labor. The uterus, after expulsion of the placenta, although firmly contracted, would not descend below the umbilicus. Both Dr. Miltenberger and Dr. Neale made careful surgical examinations and diagnosticated a fibroid tumor, apparently about the size of a man's fist, in the posterior uterine wall. Nothing of special note occurred until the eigth day, when the patient passed from her uterus a fleshy mass described by the nurse as being "like a miscarriage and resembling in consistence the gizzard of a chicken." It was thrown away by the nurse, but both physicians considered the case analagous to case I.

Dr. Neale considered these cases especially interesting as occurring in young white women, and thought the fact of spontaneous post-partum expulsion might have some bearing upon the treatment and prognosis.

Dr. Morris referred to a patient of his, who, about eight days after each of her confinements had passed a fleshy tumor from the uterus. Dr. Miltenberger had kindly attended this patient in one of her labors for Dr. Morris and had an opportunity to examine one of these tumors. Dr. Morris has seen notices of similar cases in foreign text books but has never seen them in our own.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD JANUARY 7TH, 1886.

The President, B. F. Baer, M. D., in the Chair.

PYO-SALPINX AND HYDRO-SALPINX.

Dr. Howard A. Kelly exhibited recent specimens of Pyo-salpinx, Hydro-salpinx and Papilloma of the Hilum with Gelatinoid thickening of the Fallopian tube. The histories of the cases will be given at some future time.

Dr. Gordell stated that while he recognized the necessity for operation in pyo-salpinx, he does not think it necessary in hydro-salpinx. He now refuses to operate in some cases of cystic disease in which one or any may contain a cyst as large as an orange, or in which the tube may be distended to the size of a sausage because the sufferings of the patient and her general symptoms are not severe enough to warrant the operation. In many of these cases the symptoms may all be removed by the rest treatment, and it should first be tried. Small cysts are frequently found in ovaries, especially when uterine fibroids are present, but they do not necessarily develop into large ones. In many cases the cause of pelvic symptoms can be diagnosticated by exclusion only, and even when small cysts or dilated tubes can be felt, treatment should be first tried, and will be sometimes successful without operation. He thinks the error of the present time is in the direction of too much surgical interference.

Dr. Montgomery remarked that there was a class of cases suffering from small ovarian cysts or distended tubes in which the rest treatment or any other loss of time could not be thought of, and in which an operation seemed imperative. This was on account of the pecuniary condition of the patient who may be self-supporting, or who may be the only support of others the suffering and exhaustion of the disease incapacitate them from work; relief is imperatively demanded and he considered operation justified.

Dr. Goodell recognized this element of poverty, and has operated for this reason in some instances. He was led to make his remarks by a case now under his care. A lady was sent to him for operation after an opinion had been given by an experienced gynecologist of another city that relief could be obtained by operation only. On one side the ovary was enlarged, and the other ovary was prolapsed and tender. Rest treatment had wholly cured her. In these remarks he casts no reflection on any of Dr. Kelly's cases. Pus was present in all of them, and operation seemed to be demanded in all.

Dr. Baer has been strongly impressed lately with the views expressed this evening by Dr. Goodell. Dr. Baer thought all conservative means should be tried before operating.

Dr. Kelly replied that he had presented the specimens purely from an anatomical and pathological standpoint, and that he will give the histories at some future time when the results of operation are well demonstrated. In each of them operation was imperatively demanded to save life. It is in such cases as those presented this evening that the great work in the future must largely lie. If the details of ovariotomy have been perfected, in such cases as these the chapter is only being opened. They are not examples of Battey's operation or Tait's operation, but stand as representatives of classes of disease well defined with equally well defined indications for treatment. The extraordinary difficulty of digging such masses as these out of the pelvis makes operative interference very fatal, although it is the only resort.

Dr. Wm. Goodell read a paper on

"A YEAR'S WORK IN LAPAROTOMY,"

which will be published in full in the *Medical News*.

During the past year he had forty-four cases of laparotomy, with four deaths, as follows:

	Cases.	Deaths.	Recoveries.
Ovariotomy,	28	2	26
Oöphorectomy,	9	1	8
Hysterectomy,	2	1	1
Exploratory incision.	4		4
Pelvic Abscess,	1		1
Totals,	44	4	40

Of these forty-four cases, twenty-five had been operated on at his private hospital, with two deaths; twelve were operated on at the Hospital of the University of Pennsylvania, with one death, and seven were operated on at the homes of the patients, with one death. Of these four deaths, one only was due to septicæmia and that a case of oöphorectomy occurred in a private room of the Hospital of the University. It was not, however, due to hospitalism, but to the adverse complications of the case. The ovary and oviduct were filled with pus and so matted by inflammation to adjacent structures that only a portion of them could be removed, and that in fragments. The pus unavoidably escaped into the peritoneal cavity, which was carefully cleaned, and a drainage-tube put in, yet a fatal inflammation set in. Another death was due to shock after the removal of the womb containing a fibroid tumor with extensive adhesions, and weighing seventeen pounds. The two deaths after ovariotomy were not due to septicæmia, and are somewhat mysterious. One case was operated on at the patient's home in Bedford, Pa., and Dr. Goodell did not see her again. The cyst was parovarian, weighing forty-three pounds, and was without an adhesion and easily removed. The stitches in due time were removed, the bowels were opened, and everything did well for twelve days. Then obstinate vomiting set in, and the lady died on the seventeeth day. Six months previously she had had an analagous attack of obstinate vomiting in which her life was despaired of. The fourth death took place from a supposed attack of malaria, to which the patient was liable. Both ovaries had been removed, the larger one weighing about thirty pounds. There were omental adhesions and very firm parietal ones, needing a number of ligatures. She recovered promptly from the operation, the wound united, the stitches were removed, and she was allowed to sit up out of bed. On the seventeenth day malarial fever, with bilious vomiting, set in, and she died rather suddenly on the twenty-first day with symptoms of heart clot.

Of the nine oöphorectomies, four were performed for ovaralgia, three for bleeding fibroid, one for epilepsy, and one for a menorrhagia which had resisted every known therapeutic measure.

In three cases of ovariotomy, all of them with papillary cysts, rupture had taken place a few hours before the operation; but although the peritoneum seemed thickened and injected, no bad result followed. He considered papillary cyst to be benign in the very great majority of cases, and that the danger from the escape of ovarian fluid into the abdominal cavity was very much overrated. He had not refused to operate in a single instance of ovarian tumor, no matter how the patient was or how firm were the adhesions. He had consequently had several exceedingly difficult operations. Out of his twenty-eight ovariotomies, there were twenty-one with adhesions. In four the adhesions were universal; in eight more they were intestinal, and in three they were uterine. This very large proportion of adhesions, when compared with those of European operators, he could explain only on the theory that physicians in this country have not yet been educated up to the idea of an early operation, and to a recognition of the evils of tapping. In the successful case of hysterectomy a tumor weighing eight pounds was removed, together with a portion of the enlarged womb. As the uterine cavity

was not invaded, the large pedicle was transfixed, tied and dropped. The four exploratory incisions were made with the view of removing the ovaries on account of fibroid tumors of the womb, but in each the tumor was so fixed by adhesions that the ovaries could not be reached, and the patients had previously stipulated that in that case the uterine growth was not to be removed. All did well. So also did a case of pelvic abscess communicating with the bladder and rectum. It was opened per vaginam by means of the abdominal incision, by which its exact position and size were determined. With regard to the technique of the operation for laparotomy, Dr. Goodell stated that he used the ordinary knot and the Staffordshire knot indifferently; that he now in the long incision cuts directly through the umbilicus instead of going around it on the left side; that he includes the recti muscles and all the tissues in the abdominal sutures; and that while not a very firm believer in the spray part of antiseptic surgery, he had resorted to the atomizer in every case but one, and that one did as well without it as most do with it.

Dr. Montgomery thinks Dr. Goodell should be congratulated upon his success, which is remarkable for operations in unselected cases in the United States. He thinks the knowledge of the safety attending the application of Monsel's solution to oozing abdominal surfaces very gratifying. He would have used it recently but for the fear of bad after effects. He must, however, again enter his plea for the second ovary. In young women small ovarian cysts are common, they are frequently found in post mortem examinations where there had not been the slightest evidence during life of their presence; and evidently these small cysts do not necessarily develop into large ones.

The two cases of secondary ovariotomy reported by Dr. Goodell are not sufficient to warrant the rule of removing the second ovary when it is but slightly diseased. As a counter weight to Dr. Goodell's cures, he would mention that in the instance of a young married woman from whom he removed an ovarian tumor and in which he left the other ovary, which was slightly affected, pregnancy has since occurred, followed by the delivery of a living child.

Dr. Kelly remarked that Dr. Keith had had remarkably good results from the application to oozing surfaces of a solution of per-nitrate of iron. He has observed the gradual disuse of carbolic acid in washing waters in operations. Dr. Kelly prefers boiled or distilled water as used abroad, as he is sure that carbolic acid and other germicides are frequent causes of poisoning, and bad results after operation. He asked Dr. Goodell, what were his rules respecting the use of the drainage tube.

Dr. Baer had experimented with Monsel's solution. In one case in which he used it he attributed the fatal result to it. The coagulation by the iron is unsightly, and he should now consider it a last resort. He had had very good results from pressure by packing sponges against the bleeding points combined with external pressure. He withdraws the sponge at the last moment before tightening sutures, and then bandages the abdomen tightly.

Dr. Goodell remarked that Dr. Montgomery was perfectly right in his defence of the second ovary, and he himself had performed double ovariotomy in only seventeen cases of the twenty-eight. He did not believe that every ovary studded with cysts would inevitably degenerate into an ovarian tumor. So in the case of slightly diseased ovaries in young married women he would be disposed either to let them alone or to remove the diseased portion only. But in women approaching the climacteric or where other conditions would make it advisable, he would remove the second ovary as useless in itself and as a possible source of future trouble. He had used the drainage tube but three times during the past year; once in the unfinished case of oöpherectomy, again in the case of torn bladder and in the case requiring over thirty ligatures and with universal adhesions. In general he uses it when a free oozing of blood is to be expected, but he regards it as a source of trouble, and removes it as soon as possible.

W. H. H. Githens, Secretary.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, JANUARY 14, 1886.

The President, J. C. Wilson, M. D., in the Chair. W. E. Hughes, M. D., Recorder.

Dr. T. S. K. Morton presented a

CANCER OF THE LOWER THIRD OF THE ŒSOPHAGUS, WITH METASTASES TO THE STOMACH AND LIVER,

from a woman æt. 61 years, of good family history. Her illness commenced, by her account, eleven weeks before her death, with jaundice, vomiting, constipation, and lancinating pains in the right hypochondrium. The vomiting became uncontrollable, the matters several times containing coffee-ground material. After death there was found a scirrhus cancer of the lower third of the œsophagus extending to the stomach, with no narrowing of the œsophageal lumen. The retro-peritoneal glands were involved, and the head of the pancreas slightly. Scattered through the liver and stomach were numerous secondary nodules.

Dr. Morton then presented a specimen of

CIRRHOSIS OF THE LIVER WITH PERI-HEPATITIS,

removed from the body of a woman, æt. 40 years, who been an excessive consumer of strong spirits. Symptoms had been present for five years, the most prominent of which were general œdema with marked ascites and diminution of the area of liver dulness. She died of an intercurrent attack of facial erysipelas. The liver weighed thirty-six ounces and was stongly adherent to neighboring structures. At its entrance into the liver the portal vein was much contracted, and below this point dilated.

Dr. Morton also presented a specimen of

AMYLOID DEGENERATION FOLLOWING CHRONIC DYSENEERY.

The patient, a girl, æt. 20 years, had no history of syphilis; there was a perfectly good family history. She had been in poor health, but with no positive symptoms, for two years. Last summer she had whooping-cough. After that she improved steadily till three weeks before her death, when profuse diarrhœa with high fever set in. This was the first attack of looseness of the bowels she had had. Jaundice gradually developed. The liver was found to be enlarged. The urine contained albumen and casts. The diarrhœa persisted, the passages containing blood and pus. At the autopsy the liver, spleen, and kidneys were found infiltrated with amyloid material, and the large intestine was throughout in a state of chronic dysenteric ulceration.

Dr. James Tyson said this was the first case he had ever met with in which there was this association of amyloid disease with dysentery as the etiolygical factor, although this seems the only possible cause in this case, in which the possibility of syphilitic disease seems excluded.

Dr. William Osler thought it was well recognized that chronic dysentery might be followed by extensive amyloid disease. He had met with one or two instances in connection with chronic diarrhœa, which post-mortem examination showed depended on chronic dysentery, with very much the condition of bowel present in Dr. Morton's specimen.

Dr. William Osler presented a

SPINDLE-CELLED SARCOMA OF THE RETRO-PERITONEUM WITH EXTENSIVE THROMBOTIC DEGENERATION.

and gave a history of the case. A man, æt. 60 years, was admitted to the University Hospital in September, 1884, with an abdominal tumor which had been noticed for about six months. He had lost flesh and strength, but there was no pain. The tumor formed a solid mass, occupying a median position, extending above the umbilicus; and could be readily separated by palpatation from spleen and liver. The case was regarded as one of Lobstein's retro-peritoneal sarcoma. For several weeks the patient

passed daily over seven pints of clear urine, of low specific gravity, without sugar or albumin. The patient was subsequently admitted to St. Mary's Hospital under Dr. O'Hara, and while there Dr. Mears aspirated the tumor, the upper part of which had become soft, and drew off nearly two quarts of bloody serum. At the autopsy the tumor was found to occupy a central position, was covered by peritoneum, and was attached to the tissues in front of the symphysis pubis, and seemed to have grown from the subperitoneal connective tissue in this region. The upper part of the mass was represented by a soft fluctuating cyst containing blood and shreds of firm thrombi; the greater part formed a solid mass, which on section presented a brownish-red color, was firm and dry, and had all the appearance of an old unstratified thrombus. In an area of at least 8×7 inches this remarkable condition existed. At the lower part there were two or three grayish-white masses, evidently of a sarcomatous nature. The capsule was formed of condensed fibrous tissue, beneath which in many places were recent extravasations. The weight was estimated as at least eight pounds. The lymphatic glands were not enlarged. The kidneys were fibroid. The liver presented several secondary masses, one the size of an orange. Microscopic examination showed the primary and secondary masses to consist of closely packed spindle cells. The reporter drew attention to the rarity with which spindle-celled sarcoma forms a large abdominal tumor, and to the unusual site of origin. The most interesting feature was the remarkable transformation which the greater part of the mass had undergone. This was attributed to repeated hæmorrhages and the gradual conversion of the extravasated blood into a dry, hard thrombus. Such a thrombotic change in a tumor was most unusual, and he had not been able to find reference to a similar instance. A third point referred to was the polyuria, which was doubtless due to irritation by pressure on the renal nerves. Reference was made to the facility with which the growth might have been removed.

Dr. J. Ewing Mears thought the growth could have been removed, though the removal would have been attended with some hæmorrhage.

Dr. Tyson asked Dr. Osler what, in his opinion, was the effect of thrombotic degeneration on the histological elements of tumors, and whether it was possible for clots to be converted into the tissue of the original tumor, as is asserted by some?

The President remarked that the case was of much interest from a clinical standpoint, in view of the possibility of surgical interference, and asked Dr. Osler whether the conditions as found *post mortem* suggested any means by which such a tumor as this could be diagnosticated from a similar growth occupying the more usual position in the lumbar region.

Dr. Tyson, in connection with the clinical history, called attention to the retro-periotoneal sarcoma presented by him to the Society last winter, which had been mistaken by him and others for a tumor of the kidney.

Dr. Osler, in reply to Dr. Tyson's first question, stated that the only remnants of sarcomatous tissue were two or three small but very distinct portions in the lower attached part of the tumor; the remainder had wholly undergone this thrombotic change, and in the upper part had become converted into a blood cyst. This change was no doubt slow, with first a destruction of the sarcomatous elements by the blood clot, and then a slow process of necrosis. There was no evidence in any part of the tumor of an invasion of the coagulum by the sarocomatous elements, as is not infrequent in thrombi in other regions, as he had seen in the portal and renal veins. The chief interest in the specimen lies in the remarkable extent of the thombotic change. Looking at the clinical aspect, he had diagnosticated the case as one of retroperitoneal sarcoma from its large size, its being so centrally placed, its slight movability, its distinct separation from liver, kidney, and spleen, not being placed more on one side than on the other, and from the fact that palpation in the lumbar region gave no pain or other evidence of

kidney lession. It was firmer above the brim of the pelvis than any other trumor he had ever examined. One remarkable feature about these tumors is their painless character. This man complained of no pain, and in two other similar growths, which he described at length, pain was not a symptom.

Correspondence.

THE HYPOPHOSPHITES IN POWDER.

WASHINGTON, D. C., Jan. 18, 1886.

Editor Maryland Medical Journal.

DEAR SIR:

My attention has been called to an article in your JOURNAL, under date of January 16th, entitled, "The Administration of the Hypophosphites in Powder." In a circular written quite four months since, by me, you will observe that to me belongs not only the credit of suggesting the therapeutic value of pepsin in combination with the salts of hypophosphites but the credit of perfecting and suggesting the only *chemical* combination of powdered hypophosphites with a digestive ferment yet produced. The salts of hypophosphites and their chemical relation to other elements (particularly the digestive ferments) has been a constant study of mine for the past eight years, and with the advantages of the College of Pharmacy, of Philadelphia, together with my connection with Messrs. John Wyeth & Bro., which extends back to my early boyhood, I have been able to perfect a combination of the hypophosphites with pepsin which is in *every* particular a chemical compound, and *not* a mechanical mixture.

Will you do me the kindness to make this statement public that the profession may not confound my preparation (Hypopeptine) with the formula published as they are in nowise alike, and very much oblige.

Yours respectfully,

J. S. TYREE.

BELLADONNA INJECTION FOR GONORRHŒA.—Some thirteen years ago, an officer on board one of the vessels of the Indus Steam Flotilla consulted me for a bad gonorrhœa, with intense pain on micturition, and intolerable chordee at night. The case was urgent, and I ordered an injection composed of seven ounces of water, an ounce of mucilage acacia, twenty grains extract of belladonna, and twenty grains of sulphate zinc, a teaspoonful to be injected immediately before and after micturating, and a similar amount the last thing at night; great care to be used in passing the injection fully down as far as the pain is most intense. An ointment of spermaceti and mercurial ointment, four drachms each, and ten grains extract belladonna, ten grains powdered opium, as a paste to be smeared along the perineum and around the crura penis at night. Patient left next morning. having no chordee that night, and the pain of micturition disappeared by using the injection. Within a week there was complete cure. From that time I have had numerous gonorrhœal cases of every type and stage, and without exception with unfailing success. Not long since a shop assistant presented himself with a bad gonorrhœa, high fever, inflamed testicle and chordee at night. With the application of the belladonna and opium ointment the chordee did not appear, and in four days after using the injection the running ceased, but after the first application the pain and running were much lessened. A suspensory bandage was worn, and with the daily use of the mercurial and belladonna and opium ointment the patient was quite well in three weeks. Patients have always stated that it is the injection, and not the ointment which stopped the chordee. I have tried the anodyne treatment in various classes of people, from the dissipated paupers of the Eastern bazaars to the well fed *roue* in the West; in the acute and in the chronic and gleety stages; in first attacks and in those making one of a series; and in cases complicated with inflamed testicles and chordee; and I have no hesitation in saying that I have not witnessed anything to contra-indicate it nor to mitigate its success.—*Medical Press*

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BALTIMORE, JANUARY 30, 1886.

Editorial.

FREQUENT MICTURITION IN THE FEMALE.—To Dr. T. A. Emmet, of New York City, chiefly belongs the credit of having called attention to the fact that many of the troubles referable to the female bladder have their causation in inflammations of the cellular tissue not immediately connected with this organ. At a meeting of the Obstetrical Society of New York, held November 3d, 1885, (*American Journal of Obstetrics*, January 1886, page 60.) Dr. Emmet called attention to the fact that thickening of the utero-sacral ligaments, as the result of a former cellulitis, was a condition far more common than he had formerly believed. The condition, he observed, was almost certain to be overlooked unless an examination was made by the rectum. As a result of this thickening the ligaments were shortened and constant traction was exercised upon the neck of the bladder, which occasioned a frequent desire to empty that organ. In these cases it is rare to find the bladder itself diseased. The results of treatment have proven the correctness of Dr. Emmet's views. He cited a case of a young girl who had been treated for cystitis and had even had an artificial vesico-vaginal fistula established for its relief. He had made a button-hole in the urethra, and she was relieved at once. After making a button-hole it was common to find inflammation of the urethral mucous membrane, and if this was removed the symptom of frequent micturition would soon disappear. In reply to a question asked by the President, whether the button-hole operation actually relieved vesical tenesmus, Dr. Emmet stated that it did: "By cutting through hypertrophied mucous membrane the proper circulation of the part was restored." Dr. Emmet expressed the opinion that mere displacement of the uterus had nothing to do with the symptom of frequent micturition unless the organ was in such a position as to drag upon the bladder. The irritation of the bladder he considered due to traction, not to pressure. Dr. Emmet stated that his botton-hole operation was nearly always successful in relieving cases of vesical irritation. Whenever he failed to cure a patient he ascribed the failure to a defect in the technique of the operation. The operation was not intended to cure cystitis.

LACERATION OF THE CERVIX-UTERI.—That there are many women going about their duties in a half-hearted and unsatisfactory way, because they are the victims of ill-health, it does not require the educated eye of the physician to determine. Late hours, dancing, tight-lacing and high-heeled shoes come in for their share of blame in the production of this deplorable condition, and that they deserve all the blame they receive, no one can for a moment doubt; but while making all due allowance for these agencies, we imagine that very much of this ill-health would be found, upon critical examination, to be due to unsuspected, and, in many cases, very trivial lacerations of the cervix-uteri.

These reflections are suggested by two facts: 1st. Very few physicians make a habit of examining for these lacerations immediately after labor, yet from the very nature of the parturient process they must be very common. 2d. Nearly all the ills to which women are subject, of a vague, indefinite character, (many of which are often called hysterical) are referred by our most eminent clinicians to *some* derangement of the uterine system.

Only recently, in the course of one

single lecture, Dr. Bartholow presented to his class three patients, all women who had borne children; in one there was epilepsy, in the second torticollis and in the third an excessively irritable heart. After exhausting the clinical histories of the three cases, the distinguished teacher came to the conclusion that in each case, the trouble was reflex and was dependent upon *some derangement of the uterine system*, the nature of which was not stated. It would seem very reasonable to suppose that a slight and overlooked laceration might be the cause of these troubles.

Again so high an authority as Dr. Graily Hewitt tells us that *general discomfort* and *incapability of walking*, and following ordinary avocations, frequently spoken of as "*weakness*," constitute the most generally present symptoms of chronic cervical laceration. Every practicing physician will at once recognize in this "*weakness*," the vague and almost indescribable condition of what might be turned *mid-health*, so commonly encountered among his multiparous patients and for the relief of which, the "drugs that enslave" have been resorted to until the woman is a physical wreck, while all the time the little undetected tear that has caused all the mischief, is trying in various ways to call attention to its existence.

Eversion (or ectropion) of the lining membrane of the cervix, which condition, Dr. Parvin tells us, has been for centuries mistaken for ulceration, is very likely to occur as the result of laceration and this delicate membrane is thus exposed to irritation, and rendered much more liable, according to some authorities, to cancerous changes.

The morale of these few remarks is that the accoucheur should not consider his full measure of duty performed, when the child is safely delivered and he has satisfied himself that there is no laceration of the perineum. He should go further and inspect the cervix, and if he finds a solution of continuity, at once remedy it. It is true that old lacerations can be remedied, but this can be done much more satisfactorily immediately after they have occurred, while if allowed to become very chronic, they may, by their irritant influence produce such pronounced habits of the nervous system that they will not disappear when the cause has been removed, for we must realize that this system does contract bad habits, just as habits of any other kind are contracted.

Torticollis.—Of all annoying diseases of a comparatively trivial nature, there is none to be compared to "wry neck." From one doctor to another will go the victim of this obstinate, unpleasant, rather than painful, disease. It is one of the opprobria of our therapeutics and it is the rock upon which the reputation of many a young physician has been wrecked. As a rule it is due to some reflex cause, in many cases to some uterine derangement, as we have elsewhere hinted, and such cause must be sought for and removed. If the nerves supplying the muscles of the neck are not diseased, this affection can usually be cured by patient, well directed and persevering effort. If, as we say, the cause can be detected and removed, the battle is half won.

In addition to this we will derive most satisfactory results from the combined use of galvanism and faradism; the steady, non-interrupted current to the contracted, and the *slowly* interrupted current to the paretic muscles. This interrupted current must be *slow*, for if the interruption be rapid, they will throw the muscles into a tetanic state. This procedure must be used regularly every day. Drugs, by the stomach, will do very little good, while most satisfactory results will be procured by the hypodermic injection of arsenic or cocaine into the contracted, and of strychnia into the relaxed muscles. Most wonderful results will be obtained from a system of voluntary gymnastics, directed towards bringing into play, the muscles whose duty it is to antagonize those that draw the head out of position.

By perserverance in the use of these simple means, one can frequently successfully combat this obstinate affection.

Miscellany.

Ammonia in Anthrax and Carbuncle.—Dr. Leonidas Avendano, in a paper read before the Union Fernandina, a Lima medical society, testified to the great value of ammonia in anthrax and "carbunculous diseases." Indeed, he expressed his opinion that it "is a specific, and that it should be the only drug used." In cases of malignant pustule, he advises that after an incision has been made, some drops of the officinal solution of ammonia should be introduced into the wound with the hope of destroying the bacilli there, and of the ammonia finding its way into the circulation before the bacillus does, and thus converting the blood into a fluid in which the parasite cannot multiply. In addition, some ammoniacal salt, such as the acetate, should be given internally, and on the slighest suspicion of general infection resort should at once be had to intravenous injections of ammonia, in doses of ten drops of the officinal solution diluted with an equal quantity of distilled water. In cases malignant œdema and carbunculous fever, too, "the microbe should be attacked directly in the blood, ammonia being injected into the circulation." The author detailed several cases in which immediate improvement and ultimate recovery had taken place in patients apparently moribund by the use of repeated ammoniacal intravenous injections. He concluded by claiming for Peruvian medicine the honor of having suggested and proved the value of intravenous medication in no less than four different diseases: Dr. Leno Alarco having first injected chloral in tetanus, and ammonia in septicæmia or purulent infection; Drs. Armando Vélez and F. P. del Barco having employed capsicum; and Dr. Néstor Corpancho and himself having originated the treatment above in carbuncle.—*Lancet*, Jan. 9, 1886.

The Noctural Cough of Children.—It not infrequently happens that children are waked suddenly from quiet slumber by a violent and sometimes convulsive cough. This has been ascribed by McCoy to reflex irritation from accumulation of mucus within the nasal cavities. During the day the mucus flows aways but in the night it collects upon the sensitive areas in the nasal fossæ and excites a cough. Dr. Gonzalez Alvarez thinks this theory untenable, except in a few rare instances, and attributes the cough to laryngeal irritation. He says that the saliva and buccal mucus accumulate in considerable quantities, especially when there is stomatitis or gingivitis from dentition. Most of this is removed by the acts of deglutition which take place during sleep, but some does not so escape, but trickles into the posterior commissure of the larynx. He states that this cough occurs very frequently during the period of dentition, even when there is no nasal catarrh, a fact which leads him to reject the theory of nasal reflex irritation. The treatment of this nocturnal cough consists in diminishing the secretion by means of chlorate of potassium. A teaspoonful of a two per cent. solution is given every hour or two hours during the day, and at bedtime.—*Revue Bibliographique des Sciences Medicales*, November 22, 1885.—*Med. Record.*

Juvenile Intemperance in London.—The Bishop of London, in addressing the metropolitan members of the United Kingdom Band of Hope, congratulated himself and his fellow-teetotallers on the number of children growing up in London on temperance principles. This is a good fact, upon which society is, indeed, to be congratulated. There are few subjects on which medical authorities are more agreed than in thinking that children are far better without any form of alcoholic stimulant, and juvenile education of this sort is the best counteractive of that deeply inherited vice of English children, which is the result of what Dr. Valpy French calls, in his interesting book, "Nineteen Centuries of Drink in England." Recent Christmas days have given painful evidence that all London boys, or girls either, are not of the Band of Hope. It is a pitiable sight to see boys and girls of sixteen or eighteen reeling along the streets. All honor to the Bishop and his coworkers, who, we trust, will be supported by hosts and

hostesses in the remaining holidays. The beverage at all children's entertainments should be non-alcoholic.—*Lancet.* Jan. 9, 1886.

Alcohol and Disease.—Dr. Dawson Burns, the Honorary Secretary of the London Temperance Hospital, referring to the statement made to the Local Board of Winsford by the District Medical Officer that, in his opinion, three men who lately died from what seemed an attack of cholera, owed their deaths to the refusal to take alcoholic liquor, calls attention to the fact that the alcoholic treatment of cholera has confessedly proved a failure, and that recoveries have been far more numerous where it has been dispensed with. It is an admitted fact that the ordinary use of alcoholic drink instead of being a preventive of that disease, rather predisposes to it. The superstitious value attached to alcohol in the treatment of disease is fast disappearing from enlightened medical circles; that the use of alcoholics in the great London hospitals is largely diminishing, with good results; and that the experience of the London Temperance Hospital, where alcohol has been given in only three out of three thousand in-patient cases, with an average annual mortality of five per cent during twelve years, is exposing the fallacy under which the medical officer of Winsford appears still to suffer.—*British Med. Journ.*, Jan. 2, 1886.

Trephining for Traumatic Epilepsy.—Mr. Whitehead presented at a recent meeting of the Manchester Medical Society a man, aged twenty-eight, whom he had successfully trephined for traumatic epilepsy. The patient fell down a quarry, a distance of thirty feet, in May, 1884, and received a compound fracture of the skull, for which he was treated for seven weeks in the Bradford Infirmary. Since his discharge he had suffered from constant headache, and for seven weeks preceding his admission into the Manchester Infirmary on September 29, 1885, he suffered from epileptic fits, sometimes amounting to six during twenty-four hours, and never free from headache and depression during the intervals. On October 2d, he was trephined immediately outside the area of the fracture. Nothing abnormal was observed through the aperture; nevertheless, the man had ever since, with the exception of one attack, been free from fits, and his headache and depression had disappeared. Mr. Whitehead attributed the improvement rather to reflex influences than to any direct result of the operation. He promised to report the further progress of the case.—*British Med. Journal* January 2, 1886.

Further Researches on Malaria.—In the current number of the *Fortschritte der Medicin* there appears a translation from the Italian of some further researches on malaria by Prof, Marchiafava and Dr. Celli. The chief results so far obtained are thus summed up: 1. In the blood of individuals suffering from malaria there may be found in the interior of the red blood-disks minute organisms composed of homogeneous protoplasmic particles which are endowed with lively amœboid movements, and can be distinctly stained. These organisms are only found in the blood in case of malaria, and are termed plasmodes or hæmoplasmodes of malaria. 2. In the interior of these units reddish or black pigment may be detected but it is not an essential constitutent, being merely derived from the hæmoglobin of the red disk. According as this pigmentation does or does not take place, we have or have not melanæmia. 3. The hæmoplasmodes may be tranformed by a process of fission into a group of granules which do not posses amœbid movements. This fission may occur in the pigmented as well as in the non-pigmented plasmodes, and it is most probable that this is the ordinary mode of multiplication within the human organism. Infection may occur as the result of the intravenous injection of malarial blood, as is shown not only by clinical experience, but also by the fact that in the blood of the receiver the hæmoplasmodes may be discovered. The units further increase as infection progresses, and diminish, until they disappear, as infection ceases,

whether naturally or under specific treatment. The authors, in determining some of the later points, made experiments on a man aged forty-three, who was suffering from paralysis agitans, but who had never had any malarial fever. The blood was taken from a malarial subject during his apyrexial period, and the ferbile movement commenced in the receiver the same evening.—*Lancet*. January 2, 1886.

Sugar.—Nylander recommends the use of the alkaline bismuth solution as a test, the reduction to which Fehling's solution is subject from the presence of such bodies as uric acid, kreatinin, etc., not affecting its accuracy as an indicator of sugar. The solution recommended is thus prepared; bismuth subnitrate, 2 grammes; Rochelle salts, 4 grammes; soda solution (8 per cent. caustic soda). Filter. It is to be added in the proportion of 1 to 10 of urine; 0.025 gram of glucose is easily detected. If albumin be present, it must be removed. In testing with the copper solution, the blue coloration frequently disappears and passes into yellow, owing to a reduction by kreatinin, which, by combining with the cuprous oxide produced, forms a white granular powder, thus serving as a delicate test for kreatinin. In most cases, less sugar is indicated by the polarimeter than by Fehling's solution. Müller accounts for this by the presence in many diabetic urines of a lævo-rotatory acid substance, probably hydroxylbutyric acid.—*Br. Med. Jl.*

Medical Items.

The New Congressional Directory gives the names of the physicians who are members of the present House of Representatives. The list comprises Drs. W. H. Cole and F. T. Shaw, of Maryland, Drs. I. M. Evans and L. E. Atkinson of Pennsylvania, Dr. W. H. Ellsberry, of Ohio; Dr. John Swinburne, of New York; Dr. R. T. Davis of Massachusetts; Dr. A. M. Dockery, of Missouri; and Dr. J. H. Gallinger of New Hampshire.

At a recent meeting of the Medical Society of the District of Columbia, the following officers were elected for the ensuing year. President, Dr. C. H. A. Klineschmidt; vice-presidents, Drs. J. B. Hamilton and W. H. Taylor; secretary, Dr. T. E. McArdle; Treasurer, Dr. C. W. Franzoni.

The Faculty of the University of Maryland, have elected Dr. S. C. Earle, of this city, to the position of Lecturer on Clinical Medicine at Bay View Hospital.

It is rumored, says the *Medical Record*, that the New York Pathological Society is shortly to come into possession of funds which will enable it to found a lectureship.

Mrs. Wm. D. Sloane, a daughter of the late W. H. Vanderbilt, has endowed a Maternity Hospital, which is to be conducted in connection with the College of Physicians and Surgeons of New York. All its beds will be free. It will bear the name of the "Sloane Maternity.

D. Lenoir has been appointed to the newly created chair of Cutaneous and Syphilitic Diseases, at Lille.

M. Sappey, Professor of Anatomy in the Paris Faculty, has just been elected President of the Académie de Médecine.

The forthcoming census report of Iowa contains the names of thirteen individuals 101 years old, three 102, one 103, two 104, one 105, one 106, one 107, and one 108. Jacob Heike, of Grundy County, is said to be 121 years old, and Mary Brennan, of Story County, 112.—*Med. Herald*

The term of the present Health Officer of New York City, expired some time ago, and it is only because a "deal" could not be made that he or his successor has not been appointed. Among the persons who are now reported to be aspirants for the position are Drs. F. R. S. Drake, Charles Phelps, A. Flint, J. C. Hutchinson, T. S. Bahan, and L. Foster.—*Med. Record.*

Original Articles.

ON THE TREATMENT OF CERTAIN FORMS OF CHRONIC MALARIAL DISORDERS.*

BY SOLOMON SOLIS-COHEN, A.M., M.D., OF PHILADELPHIA.

Chief of Clinic, Out-Patient Medical Department, Jefferson Medical College Hospital.

This paper does not aim at the presentation of anything very new or very startling. The affections to the treatment of which consideration will be directed have been so thoroughly studied and are so familiar to all, that such an attempt would be superfluous. A moderate experience, however, especially in dispensary practice, where one is more apt to meet with the cases of neglected disease, leads me to think that it will not be unprofitable to compare the effect of well-known methods of treatment in an every day group of disorders. One often hears the expression: "Malaria is like charity, covering a multitude of sins." Now, while it may be true that an incorrect diagnosis of malarial poisoning is sometimes made in instances in which a more careful examination or a more skillful analysis of the morbid phenomena would lead to a different and correct conclusion, I am inclined to believe that such mistakes of diagnosis are very infrequently made by physicians of ordinary intelligence and education; and that one is more apt to overlook the connection of miasmatic infection with an obscure case of disease, apparently affecting this, that or the other organ, or group of organs, than to cry, "malaria" as any easy method of dismissing a puzzling subject.

It is not proposed, however, at present to discuss, except casually, the question of diagnosis. Assuming that our patient has been examined carefully, and with due skill, and that the diagnosis of chronic malarial poisoning is correct, how shall he be treated?

The value of quinine is, of course evident. But is this remedy the only one, or even the best one in all cases? No one will say that it is. Opinions differ, however, as to the exact indications for its use, or the best method in which to employ it. And so with other classical remedies. The most contradictory assertions as to their comparative value have been made; while general professional opinion has, nevertheless, assigned to a number of them positive anti-malarial virtues, and one practitioner resorts, with a confidence born of and justified by success, to a drug which another practitioner condemns as useless. In endeavoring to ascertain by promiscuous trials, without reference to the dicta of the text-books, the value of a number of the more highly esteemed drugs, there appeared to be a certain number of instances in which one remedy was superior to any of the others, and upon further observation it seemed that groups of cases, presenting certain general features in common, were thus therapeutically differentiated; so that by assigning any case to its proper group, in accordance with these features, it could be predicted which of the remedies experimented with would prove most beneficial in that particular instance.

The conclusion thus arrived at, I desire to briefly lay before the Society this evening, again premising that they are neither very new nor very startling. The drugs investigated were the cinchona alkaloids, salicin and it derivatives and compounds, iron, arsenic and iodine.* I regret that my notes are not complete enough to enable me to present a statistical table, but that I can only give general results. Cases with profound organic disturbances, such as ascites or anasarca, great melanæmia, hæmatinuria, profound nervous derangement, etc., or in which splenic or hepatic enlargement was so marked as to call for treatment specially directed to that condition, are not included in these remarks.

First, as to quinine, which, as the best of the group, may stand for cinchona preparations in general: It will be generally conceded that the value of this

*Read before the Philadelphia County Medical Society, November 11th, 1885.

*Eucalyptus, hydrastin and creasote are under observation, but I am not yet prepared to make any positive statements as to their utility.

drug is not so preëminent in chronic malarial disorders as in the acute, frank, intermittent or remittent fever. Its greatest applicability seemed to be in two groups of cases: 1st. In those cases in which the manifestations —whether they are febrile or afebrile; whether they succeeded a neglected or insufficiently treated acute fever, or were chronic, and insidious from the outset—exhibited a more or less distinct periodicity. 2d. In those cases, often subacute rather than chronic, and yet usually the result of a prolonged exposure to the exciting cause, or of a fresh exposure in a person, the subject of chronic malarial toxæmia;—that group of cases, including brow pain, some cases of so-called dry pleurisy, etc.—which are usually termed "masked malaria," or "dumb ague." In the first group of cases, given in sufficient doses during the twenty-four hours preceding the expected paroxysm, quinine acts as an efficient preventive; but it is not to be depended upon to remedy the underlying toxæmia, which prolongs the time during which the periodic outbreaks regularly recur. For if we intermit its use, we will find that after one or two paroxysms have been missed the outbreak will again occur, even through the violence may be moderated or the character of the symptoms modified. In other words, quinine, in chronic malaria, is a prophylactic against exacerbations rather than a remedy. In the second group of cases, quinine employed as in ordinary intermittents or remittents, to "break up" the attack, and continued in small doses, daily, for three or four weeks, with a full dose in anticipation of each seventh day, or if the periodicity be differently manifested, each third or sixth or ninth day (as the case may be), will sometimes bring about complete recovery. If, however, recovery is delayed beyond four weeks, the cases then seem to do better under some one of the other remedies, with, perhaps, a full dose of quinine occasionally, in anticipation of an expected paroxysm, as in the first group.

It was long ago observed that in some cases of masked intermittent, without distinct periodicity, one of the first manifestations of approaching recovery was that, under the influence of a cinchona preparation (this was even before the days of quinine), the vague pains and aches would suddenly give place to a pronounced fit of ague, with chill, fever and sweat more or less classically regular.' This fact, in connection with the relapse noticed on withdrawing quinine, as just mentioned, suggested the following plan of treatment: To give quinine, either alone or in combination with one of the other remedies deemed appropriate, and to continue the use of the drug for about a week, or until some improvement should be manifested; then to stop medication and wait for the relapse. This would usually come either in the form of chilliness, followed by fever, and, perhaps, sweating; or else one of the symptoms previously complained of would manifest a periodical aggravation. By carefully noting the periodicity, it then became possible to employ quinine as a prophalactic, in advance of the paroxysm, either by divided doses during twenty-four hours, when the periodicity was certain, or longer, or by one or two decided doses, four hours, or eight and four hours, respectively, in advance, when the manifestations were quotidian; arsenic or other drug being given in the intervals.

According to my own experience, the most effective salt of quinine is the so-called bimuriate of quinia and urea, which I was led to employ by learning of Prof. Bartholow's high opinion of its virtues. I have elsewhere published some cases illustrative of its value in acute remittent fever, and in a case of prolonged and severe intermittent fever, in which quinine sulphate in doses of sixty grains *per diem* had only succeeded in changing the type of the disease from a double quotidian to a single quotidian. The cases herewith briefly cited are illustrative of its virtues in chronic cases, and also go to confirm the opinion already expressed, that quinine in these cases is a prophylactic, but not a remedy. The bimuriate of quinia and urea is perfectly soluble in its own weight of water, and hence adapted for use hypo-

dermatically. The objection to it is, that unless extreme care is taken not to allow a drop of the liquid to touch the skin, and, sometimes, in spite of every precaution, a very sore arm or even an abscess may result. It is good practice to paint the arm at and around the point of puncture with tincture of iodine.

Case I, was a young man, living near the Delaware river, and working along the wharves at Port Richmond. He had had repeated attacks of chills and fever for ten years; exhibited marked malarial cachexia, the spleen, however, being but slightly enlarged. For about a month he had been suffering with irregular chills, sometimes followed by fever, and for two weeks had had daily chills. He was seen during the cold stage, about 2 P. M.; temperature 100°. An injection of fifteen grains of bimuriate of quinia and urea was given. The hot stage was averted, and the patient remained perfectly well for six days. He then had another chill, and an injection of ten grains of the same drug kept him well for a week, when he had a chill as before. He was then placed upon salicylate of cinchonidine and iodide of arsenic, and during three weeks longer that he remained under observation, had no further chill. From the fact that he did not return, I presume this subacute exacerbative attack was completely checked. Of course he was not under treatment long enough to rid him of his cachexia.

In the second case, very similar to the above, but with marked enlargement of the spleen, the quotidian intermittent, for which the patient sought relief, had lasted three weeks. One injection transformed it into a quartan, and the next prevented any further chill for a week. The patient was then placed upon salicylate of cinchonidine and arsenic, and is improving under this treatment.

While on the subject of the bimuriate of quinia and urea I would refer to a case recently treated at the Jefferson Hospital Medical Clinic. A man, while in the waiting room was seized with the cold stage of a tertian intermittent, that he had had for two weeks. His temperature at the time of injection of fifteen grains of the bimuriate of quinia and urea was 105°. He had no subjective fever, and went home happy half an hour after the injection. He returned the next chill-day, with a normal temperatare. Nothing was done, and the day after the next chill-day, that is, the sixth day from the day of the injection, inclusive, he returned, and had a slight shiver, his temperature being 99°. After a second injection he remained free from chill for two weeks. He was then placed upon cinchonidine salicylate, and recovered without any subsequent paroxysm. This man would have recovered, doubtless, under the ordinary quinine treatment. I only cite the case in illustration of the rapid and continuous effect of the hypodermatic injection of the drug in question, and as a contribution towards data for determining the manner in which the cinchona alkaloids prevent the recurrence of malarial paroysms.

In the cases so far spoken of, the malarial element is pronounced. There are, however, other cases, where an element of doubt enters into the diagnosis, but which are, I think, properly called chronic malaria. We will now speak of them. In cases where the patient is hard worked, ill-fed, run down, exposed constantly, if not to malarial infection, to deleterious surroundings, and especially if there be exhibited a tendency toward the establishment of anæmia; in other words, in those cases wherein vital depression seems to be the most evident effect of the poison; whatever treatment be adopted, iron forms a valuable adjuvant. A formula which has been used with success by Dr. Rush Leaman, my predecessor at the Jefferson Hospital clinic, consists of sulphate of cinchona, dilute nitro-muriatic acid and tincture of the chloride of iron, in elixir of orange.

My personal preference is for the iodide of iron, at first in small doses, rapidly increased to as large doses as the stomach and intestines will tolerate, and then gradually diminished. In many of these cases, iodine seems to replace

quinine and do away with the necessity for any cinchona preparation. In other cases, peruvian bark, or some of its alkaloids, must also be used, in such doses and at such intervals as the nature of the paroxysm may indicate.

A pill of arsenic and iron, or a mixture of the tincture of chloride of iron with Fowler's solution, is often of great service. In a case of great interest diagnostically, at the Hospital clinic recently, Prof. DaCosta prescribed tincture of the chloride of iron in combination with solution of chloride of arsenic. Arsenic, however, appears to find its greatest usefulness in cases which, like the one just referred to, do not present a typical picture of malaria; where the disease is manifested in vague neuralgias, headaches, attacks of nausea, even vomiting without adaquate cause, such as dietary indiscretion or gastric disease; in "nervous dyspepsia;" in simulated phthisis; in cases where the patient, even when well nourished and apparently robust, seems indisposed to exertion, either mental or physical; those cases of chronic masked malaria which have been termed "neurolytic;" in a word, in those cases where the effects of malaria poison seem almost to have become localized in the nervous system. It is, however, also of great utility in cases of neglected, long-continued intermittent fever. At the Jefferson Hospital clinic, Prof. DaCosta is in the habit of prescribing Fowler's solution in such cases, after the paroxysms have been brought under control by large doses of quinine, continuing moderate doses of quinine every morning.

When the pains and aches complained of are located in muscles—favorite seats of such location seeming to be the back of the neck, the shoulders, especially the right shoulder, and the lumbar region—and when they are rather rheumatoid than neuralgic in character, such cases, indeed, as one sometimes sees treated as chronic muscular rheumatism, the salicin group of preparations are of decided benefit. Cinchonidine salicylate, combining, as it does, salicylic acid and a cinchona alkaloid, has seemed peculiarly valuable. It has also appeared superior to quinine sulphate, in cases marked by vague chilly sensations and irregular febrile manifestations, yet lacking the frank chill, with its subsequent stages of fever and perspiration. These cases can sometimes be clearly differentiated from the former group (nervous cases), but often the two are mingled. In these mingled cases, a combination of arsenic and cinchonidine salicylate is often more effective than either drug alone.

Iodine, which, according to some observers, especially Russian and Anglo-Indian physicians, is of the highest value, even in acute cases, and according to others is of no value whatever, has seemed to be of benefit in all groups of chronic cases, and particularly in those which, however, the phenomena may be attacks of intermittent or remittent fever; in other words, those usually classed as cases of malarial cachexia. It is not efficient, however, if employed alone. In those cases where quinine is used to break up the paroxysms, iodine serves a good purpose in the intervals. It may be used in the form of tincture or of compound tincture, or of compound solution, given in water, in simple elixir, or in elixir of cinchona, or in tincture or compound tincture of cinchona, when the influence of bark is desired. In cases where arsenic or iron seems to be indicated, better results have sometimes appeared to follow the use of the iodides of these metals than that of any other preparations. Iodine in metallic form, or in aqueous or alcoholic solution, can, however, be mixed with an appropriate arsenical or chalybeate preparation, if that be preferred to a definite chemical combination. At the Jefferson Hospital clinic, the iodide of ammonium was introduced by Prof. Bartholow, with gratifying results. In one case, of subacute exacerbation of long standing malarial disease he prescribed a combination of iodide of ammonium with Fowler's solution, and in addition thereto, pills of cinchonidine salicylate. A pill which I have employed with apparent good results, consists of cinchonidine salicylate five grains, and iodide of arsenic $\frac{1}{24}$ to $\frac{1}{12}$

In all cases, it is, of course, tak n for

granted that proper hygienic and dietetic measures should be instituted, and that the activity of secretory and emunctory functions should be preserved and stimulated. Summing up the points set forth in a desultory way in this communication may be recapitulated as follows:

I. That quinine salts are of greatest value in those cases of chronic malaria showing distinct periodicity, and especially if there be a febrile paroxysm; and that in such cases their chief value is prophylactic, rather than curative. That the administration of quinine until relief is manifested, and then the withdrawal of the drug, will sometimes bring out a periodicity otherwise masked. The bimuriate of quinia and urea, hypodermatically, is the preferable salt in acute or subacute exacerbation occurring in the subjects of malarial cachexia.

II. That in cases where the patient is much run down and exposed to unsanitary conditions, iron should be part of the medicinal treatment.

III. That where the most prominent symptoms are connected with the nervous system, including apparent pulmonary, cardiac, intestinal or gastric troubles, arsenic is indicated.

IV. That where the most prominent symptoms are rheumatoid or myalgic in character, salicin, or some of its derivatives or compounds, is of advantage; cinchonidine salicylate, by preference, in order to obtain the anti-malarial virtues of the cinchona alkaloid. Cinchonidine salicylate is also of use in maintaing an effect produced by quinine, after the withdrawal of that drug, and is superior to quinine where the paroxysmal manifestations are vague and irregular.

V. That iodine is of some benefit when administered alone, and of decided benefit when combined with other remedies.

In the United States, the last census shows the existence of 563 establishments manufacturing proprietary medicines employing over four thousand persons and having an investment of over $10,000,000, with annual production of over $14,000,00 of proprietary articles.

HEALTH AND LIGHT.

BY AUG. V. GOSWEILER, M.D.,
OF BALTIMORE.

As, from one cause and another, health problems are just now absorbing much public attention, both in this country and in Europe, it is not without reason that *Engineering*, a leading British scientific authority, devotes its chief editorial space in a late issue to a discussion of the influence of artificial light upon health.

Up to a recent date all artificial illuminators have involved the combustion of the oxygen of the air, and it was never expected that light could be obtained from lamps in any other way. That a single gas jet in a room consumed about as much of the oxygen of the apartment as half a dozen persons was accepted as a disagreeable necessity; and so, also, was the throwing off of certain injurious vapors, as the products of the combustion of gas, oil or candle. But exact research shows that there is a great difference in the degree of these chemical changes, according to the illuminator employed, and this must be one of much public interest, although so little is generally known about it.

It appears then from the tables of Dr. Tidy, as cited by the authority just mentioned, that, if burned to give a light equal to that of twelve sperm candles, burning 120 grains an hour, cannel coal gas, such as is used in Glasgow, would vitiate 217 cubic feet of air each hour; common gas, 348; sperm oil, 357; benzole oil, 376; paraffine oil, 484; camphene, 510; sperm candles, 615; wax candles, 632; stearine candles, 669; tallow candles, 933. As a matter of fact, we all know that ordinarily whenever we resort to candles we put up with a small fraction of the light demanded from gas; but if we choose to get the same amount of light it must be at an enormous cost of deterioration in the air. Among candles themselves the sperm seems to be the least destructive of oxygen for the quantity of light given out; and a German chemist, Ferd, reaches a conclusion in regard to the

amount of deleterious carbonic acid thrown off by sperm candles not generally different from that of Tidy.

But taking common gas, which stands very high on the foregoing list, it is evident that a room in which it is burning should be frequently ventilated. One of the greatest nuisances of some brilliantly lighted theatres in this city is their failure to have a proper supply of ventilators or air shafts. Carbonic acid gas, or what the miner expressively calls choke damp, is the poison contributed to the atmosphere by a flame. It has been shown that there is twice as much of this in the dress circle of the Haymarket Theatre, London, at 11.30 P. M., as in the streets outside; four times as much in the underground railway as in the open air; five times as much as in the Chancery Court, seven feet from the ground, and twenty times as much in an average mine.

The consumption of oxygen and the loading of the air with carbonic acid are not the only evils charged by *Engineering* upon ordinary illuminators. There is the smoke or soot of inferior candles and lamps; and there is the gas itself; since, except in very good burners, a large proportion is given off unconsumed. Dr. Griffin, of Bristol, is the authority for the additional assertion that "sixty burners will produce on the lowest computation two gallons of water per hour; hence in a November evening many large shops filled with delicate goods will have a nine-gallon cask full of water thrown into the atmosphere in the form of steam, to condense on any cool surface, as we often see it trickling down the window in winter." Another chemist shows how the sulphur always present in gas made from coal passes into the air as oil of vitriol; indeed, librarians who really watch and cherish their treasures have long known that gas will in time rot the leather binding of books, discolor cloth, and rust metals. Dr. Letheby has collected statistics of such destruction, one curious demonstration being that of a book which had been missing thirty-six years, and was discovered sound and strong, while volumes kept in the library, in the same leather binding, had given way. The fading of dyed fabrics at the edges if long kept on the upper shelves of dry goods stores is assigned to the same cause. For these reasons and for freedom from fire risks, electric light has lately been substituted in the library of the British Museum.

The moral drawn by our technical contemporary from these and other facts is that electricity furnishes by far the most healthful light. There are drawbacks of expense against its universal employment, and doubtless other considerations could be urged in the same direction. But there is certainly an advance in illumination, as our authority suggests, from the old-time torch and candle, which burned a solid, through the oil lamp, which burns a liquid, and then the jet of gas to the "more ethereal source" furnished by electricity which is now in vogue.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JAN. 8, 1886.

After the regular order of business, *Dr. H. Clinton McSherry* related a case of

DIPLACEMENT OF THE HEART TO THE LEFT, DUE TO CONTRACTION OF THE LUNG ON THAT SIDE.

The patient, whom he presented to the Society for inspection, is a man æt. 32 years, who has never been very strong, but especially during the last year has he been losing flesh and strength. He has had dyspepsia for the past fifteen months and for six months has been greatly troubled with shortness of breath. Six months ago he was attacked with hæmoptysis, which has recurred several times since, varying in amount from a tablespoonful to a half pint of blood. He has had inflammatory rheumatism and has a most pronounced family history of heart trouble, his grandmother, aunt and sister having died suddenly from this disease. There is no

family history of phthisis. Physical examination of the left side of the thorax reveals consolidation and retraction of the lung, with a cavity at the apex in front and another at about the lower angle of the scapula behind. The right lung gives evidence of very slight deposit at its apex. The left side of the chest measures at the line of the costal cartilage, fifteen inches; right side measures at the same level, sixteen inches, showing the left to be one inch smaller than the right. At the fourth costal cartilage the left side measures 15 inches, while the right side measures 16⅛ inches, showing a difference at this level of 1⅛ inches in the same direction. Apex beat is felt a little over two inches to the left of the left nipple, in the sixth intercostal space. In percussing from right to left the heart dullness is found to begin a little over 1½ inches to the left of a line drawn longitudinally through the centre of the sternum.

The patient has phthisis with cirrhosis of the left lung, with cavities at apex and at the angle of the scapula. No valvular lesion of the heart exists.

The point in this case to which Dr. McSherry wishes to call particular attention is the marked displacement of the heart to the left side owing to retraction of the cirrhosed left lung, which had occurred without any history of pneumonia or pleurisy.

Displacements of the heart, may be to the right or left, upward or downward, though the latter must be very unusual, for he was inclined to agree with a late author, who says "the heart hangs in the thorax like the pendulum of a clock and when moved from side to side is raised." He said that the heart could be displaced by being pushed aside by any increase in bulk of the contents of one side of the thorax; indeed it is one of the signs of pleurisy, pneumothorax, etc., but records of cases in which the heart is drawn toward the affected side are comparatively rare. Displacements to the left from such a cause he thought much more rare than to the right. He had seen one such case (reported by Dr. S. C. Chew), and had heard an interesting report of another by Dr. W. J. Jones at the last meeting of this Society.

He had also seen one case of complete transposition of all the viscera, but had never before met a case in which the heart was *drawn* to the left side by cirrhosis of the left lung, without a pre-existing history of pleurisy. He thought this displacement to the left might be mistaken for hypertrophy and dilatation of the heart.

Dr. Randolph Winslow wished to know if Dr. McSherry thought a man could have cirrhosis of the lung without having phthisis.

Dr. McSherry—I have stated that this man has phthisis.

Dr. Winslow.—Do you think he could have cirrhosis without having phthisis?

Dr. McSherry.—He might have a chronic interstitial pneumonia.

Dr. Winslow.—You think then, that he might have cirrhosis without phthisis?

Dr. McSherry.—No, I should say he could not have cirrhosis without phthisis, but in making this statement, I wish it to be understood that I make a distinction between the terms phthisis and tuberculosis.

Dr. Frank West then reported a case of

SUCCESSFUL LAPAROTOMY FOR INTESTINAL OBSTRUCTION.

Dr. Randolph Winslow also reported a case of

INTESTINAL OBSTRUCTION SUCCESSFULLY TREATED BY LAPAROTOMY.

The two cases were discussed together.

Dr. L. McLane Tiffany thought the Society should congratulate itself on having two such successful operations reported on the same night by two of its members. These are, so far as he is aware, the first recoveries from this operation in this part of the country.

Dr. W. T. Councilman can readily appreciate the difficulties that a surgeon encounters in doing this operation. It

frequently becomes necessary for him, even in making autopsies on patients who have died as a result of intestinal obstruction, to remove the contents of the abdominal cavity *en masse*, before the exact point and nature of the obstruction can be made out.

Dr. J. Edwin Michael said it was the appreciation of just such difficulties as referred to by Dr. Councilman, that caused in Winslow's case the opening of the inguinal canal. It was impossible to say that the irreducible tumor in the groin played no part in the obstruction until its condition was investigated by operation and only when it was found to contain fluid and no intestine was the obstruction sought elsewhere. He thought the great amount of manipulation necessary in Dr. Winslow's case made it a less favorable one for recovery than Dr. West's. A comparison of the two cases was very favorable to the claims of antiseptic surgery. In the worse case of the two strict antiseptic precautions were taken and a rapid uneventful recovery followed, while in the other case in which less exposure and manipulation of the intestines was required to overcome the obstruction there was more or less trouble. He was not of the opinion that the chill that occurred on the eighth day in Dr. West's case was of septic origin.

Dr. West said that he thought Dr. Michael's criticism of his case was very correct and that if he had the operation to do over again, he would observe all antiseptic precautions.

Dr. S. T. Earle asked if the cæcum was distended in Dr. Winslow's case.

Dr. Winslow said, in reply to Dr. Earle's question in regard to the condition of cæcum, that he felt for the cæcum and then passed his hand over the large intestine without discovering anything abnormal, but owing to the distended condition of the small intestines, which filled all available space, that was not to be wondered at. The cæcum was, however, collapsed as was proved subsequently after the constriction had been overcome. It is not easy by the sense of touch alone to distinguish the different portions of the intestines, a fact which is strongly emphasized by a recent English writer.

Dr. J. W. Chambers said, in comparing the two results reported, he could not see that Dr. Winslow's case performed under rigid antiseptic precautions, had any advantage over Dr. West's case done with but little regard to the details of antiseptic surgery He would just as readily operate without such precautions as with them.

In operating for hernia, he said, the abdominal cavity is practically opened and up to a very few years ago no one ever thought of using any special antiseptic methods in this operation. He said our most successful operators in abdomnal surgery were not strict antiseptic ists.

Dr. W. T. Councilman asked Dr. West, if, at the time he operated, there was any existing peritonitis.

Dr. West said, when he opened the abdominal cavity the peritoneal coat of the intestines was very red. He took it to be an inflammatory condition. No lymph nor serum was present.

Dr. Wm. P. Chunn knew of two cases that he thought could have been saved had laparotomy been performed. He asked why Dr. Winslow had not enlarged his abdominal incision instead of making an opening over the inguinal canal. Would it not have been easier to sew up the abdominal wound with one single set of sutures going through the whole thickness of the walls, than to make two sets one for the peritoneum and one for the skin and muscles? He has used the single suture in five successful cases of laparotomy and has never had any pus get into the peritoneal cavity When he sews up the wound with this single suture it his custom to hold a flat sponge beneath the incision to catch all escaping blood, and thus prevent its entrance into the abdominal cavity while the needle is being passed. This is impossible when Dr. Winslow's plan is adopted.

Dr. Winslow, in answer to Dr. Chunn, said he made a small incision at first, because he hoped to be able to relieve the trouble without incurring the increased risk of a long incision. He used the form of suture employed, because it

is certainly desirable to separate the peritoneal cavity from the wound, and sometimes when the skin incision fails to unite the peritoneum will hold, and thus prevent the access of germs into the peritoneal cavity. The only change he would make in the manner of closing the wound would be that instead of passing sutures entirely through the abdominal walls, as was done in this case, he would unite the peritoneum separately with continuous catgut suture, and then pass the deep sutures through all the tissues external to the peritoneum. In this way the danger of pus passing backwards into the peritoneal cavity would be remarkably diminished. He did not operate upon the supposed hernia first, and subsequently open the abdomen, because there was absolutely no evidence of strangulation; after opening the abdomen a condition of affairs was found which, in his opinion, demanded the herniotomy, though it was by no means certain in the mind of the operator and of his chief assistant that they had to deal with an incarceration of the gut. When no intestine was found in the sac, he was assured that the constriction was elsewhere. Whilst an error in diagnosis to this extent was made, it did not in any way complicate the case, and, on the contrary, resulted in a cure of the sac, whatever the nature of it may have been. Dr. Chambers is in error in supposing the case of Dr. West to have been more desperate on account of the peritonitis which was present at the time of operation. In neither of the cases was there any lymph or effusion from the intestines, hence though both were deeply congested, peritonitis had not set in in either. The statement that both cases terminated favorably, and therefore, the rigid antisepsis of the one had no advantage over the less stringent precautions of the other, and that the good result in both was entirely independent of the use of antiseptics, is scarcely borne out by the facts. It certainly would seem that the maxim "tuto, cito ac jucunde" was as applicable here as elsewhere. It is a mistake to say our best operators discard antiseptics. If by "our" is meant American, it is undoubtedly an error. Homans, of Boston, and Battey, of Georgia, are the most successful American operators, and they are rigid antisepticists. Keith, who is probably the most successful operator in the world, likewise employs antiseptics.

There has been much written of late upon the treatment of intestinal obstruction, and there is considerable diversity of opinion in regard to it. Mr. Hutchinson, one of the best practical surgeons in England, is opposed to operative treatment until all other means have failed. He advocates abdominal taxis, which consists essentially in a series of rough manipulations of the abdomen, shaking the patient, inverting him, tossing him a blanket, &c., with large enemata, the internal use of opium and belladonna, and anæsthesia. If this does not succeed he waits, puts the patient on low diet, and repeats the taxis. Treves and others advocate early operation, as soon as it is clearly established that the case is one of obstruction. Illoway, of Cincinnati, advocates the use of enemata under strong pressure. The method of abdominal taxis is dangerous, and is likely to cause rupture of the bowel or loosening of an intussusception, or increase of the hernia instead of reducing it. Enemata, under strong mechanical pressure, are also dangerous. Abdominal section offers the best chances for success, if simple means fail. Sometimes the constriction is a simple band, which can be easily divided, as in a case seen by the speaker, where the band was only as thick as a few strands of horse hair, or, as reported by an English surgeon, when the vermiform appendix constricted the ileum.

Dr. Winslow, in conclusion, said three symptoms were sufficient indication for the operation—obstinate constipation, severe intestinal pain (especially when the coils of intestine can be seen and felt through the abdominal parietes), and stercoraceous vomiting.

Dr. N. G. Keirle had, some years since, had a patient, æt. 85, who had perfect stercoraceous vomiting and swelling in the femoral region. He cut down upon the swelling, and found a sac with nothing in it. He suggested opening

the abdomen, but as his consultant did not agree with him, the idea was abandoned. He asked if Dr. Winslow was sure his case was not one of intussusception?

Dr. Winslow was sure it was not.

Dr. L. McLane Tiffany did not think there was any peritonitis in Dr. West's case, as there was no exudation either of lymph or serum. Thought the redness of the peritoneum due to congestion. He would call attention to a phenomenon that he had often observed in twenty-seven cases of strangulated hernia upon which he had operated, and of which he had notes, if vomiting prior to the operation was present then vomiting took place during or immediately after reduction. It had occurred in both cases reported to-night. He thought it had relation to relief. Considered it a favorable prognostic sign. It may or may not be accidental; however he considered it worthy of consideration. Where obstruction is complicated with femoral or inguinal hernia washing out the stomach has reduced it, and vomiting after reduction may be a reversed action not evidence of strangulation. If inverting the patient does not liberate the knuckle of intestine, he thought it better surgery to open the abdomen than to cut wildly over the veins.

He had not operated upon a single case of strangulated femoral hernia in which the patient did not complain of pain in the region of the umbilicus. Took this to be important as a point in diagnosis.

A marked hyperæmia of a limited portion of the intestine often gives rise to symptoms closely simulating those of obstruction.

He thinks the persistent vomiting, after reduction of a hernia, due to a localized hyperæmia and an atony of the gut at the point of constriction. Did not think Dr. West's case should be cited as one that recovered without antiseptic precautions. In his opinion sufficient antiseptic detail was observed. Looks upon the comparison between the two cases as not being altogether a fair one, as the conditions were far from being parallel.

Did not think the chill on the 8th day in Dr. West's case was the result of septic poisoning, but was probably malarial.

Dr. S. T. Earle said he did not think that one should be content with finding but a single obstruction. Others should at least be sought, for a case had recently been recorded in which the patient died from a second obstruction that had existed at the time the first one was reduced.

Dr. J. Edwin Michael said, in regard to the remarks made by Dr. Chambers, which were opposed to the importance of antiseptics in surgery, it was usually recognized at present by surgeons that unless you have especially adapted apartments in which to operate it is essential to the success of the operation, and is due your patient, that every precaution should be observed.

Dr. Chambers had gone far astray in saying that most of our abdominal surgeons do not use antiseptic precautions, and especially in including Keith in that category. Keith has given up the spray, but as I am credibly informed by one who has recently seen him operate, he uses the most rigid antiseptic precautions in all other respects. It is true that Tait has had wonderful success with simple cleanliness; but it must be remembered that he operates in a private hospital where every detail of cleanliness is managed with scrupulous care. He avoids the causes of septic troubles as could not be done in a general hospital or private house. In regard to the unfairness of a comparison of the two cases referred to by the President, I have only to say that the more they are compared the more apparent is it that Dr. Winslow's presented the more unfavorable features, and in regard to the sufficiency of antiseptic precautions, I can only refer to the candid admission of Dr. West, that in this case the antiseptic preparation was very incomplete.

Dr. J. W. Chambers did not think statistics would show any advantage for strict antiseptic surgery.

Dr. N. G. Keirle thinks the operation should be done early, before inflammatory softening has begun, if not, one incurs the risk of rupturing the gut during manipulation.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

STATED MEETING, HELD NOVEMBER 11TH, 1885.

Dr. Solomon Solis-Cohen read a paper

ON THE TREATMENT OF CERTAIN FORMS OF CHRONIC MALARIAL DISORDERS.*

DISCUSSION.

Dr. J. C. Wilson.—In this city we occupy a topographical position which makes us liable to malarious influences and to outbreaks of malarious disease. This is shown by historical experience. Half a century ago frank malarial affections, intermittent and remittent fevers, were very common. I think, from my own experience and that of others, that such frank cases must now be uncommon. In regard to the banks of the Schuylkill and of the Delaware, while acute frank cases are of common occurrence, both above and below the city, I think that it is rare to find such attacks developing in those who live near these rivers in the city who have not been exposed to malarial affection in some other locality.

I, however, do see a large number of patients suffering with diseases which are characterized by more or less periodicity, evidently of malarial origin, in which the so-called antiperiodics are curative.

With reference to treatment, I would say that where periodicity is marked, I believe that the alkaloids of cinchona are to be preferred. Notwithstanding the relative high cost and the occasional difficulty of administration of sulphate of quinine, I believe that it, in the end, is really the least expensive and the most satisfactory remedy. This is true only of cases where periodicity is well marked, and while it is well marked. As soon as this periodicity is lost, or there is only a wave-like approach to periodicity in the recurrence of the symptoms, we must fall back on other remedies. I then use either potassium or sodium arsenite, or arsenious iodide. I prefer to give arsenic alone, beginning with a moderately full dose, getting some evidence of the physiological effect, then diminishing the dose, and if there is indication for the use of iron, alternating the arsenic with this remedy. With the bimuriate of quinia and urea hypodermically, I have had no experience except in one unfortunate case in which a serious sore resulted.

Dr. Collins.—I have been much interested in the paper. I think it important to discriminate between malaria of the swamps and malaria of the city. I think that we shall have to modify our ideas of malaria somewhat. The malaria which I saw along the Potomac and James rivers, and in camp differed much in intensity from that which I see here.

I have been much interested in the treatment, for that agreed with my experience. Two years ago I began using the bimuriate of quinia and urea. I find it a desirable remedy.

Dr. Watson.—For more than fifteen years I have practiced in the western part of the city, following the banks of the Schuylkill from Market street to beyond Callowhill. For the last five years I have not seen a case of clear intermittent fever in any person residing and continuing to reside in that neighborhood. Where such cases have occurred, the patients have been exposed in places notoriously subject to that disease. I have met with remittent fever with great frequency, so much so that some time ago every case of labor that I delivered in the neighborhood of the Schuylkill developed remittent fever. These were all cured by quinine.

In regard to chronic malaria, I have seen it frequently arising in people living in damp houses and exposed to bad air, especially in persons returning from the country or from the sea-shore. The cases of a rheumatic type commonly developed in those returning from the sea-shore. In these cases, salicin has seemed to act more promptly than the salicylic acid compounds. Salicin and arsenous acid have seemed more efficient than quinine.

In 1865–66 the attempt was made in the Episcopal Hospital to treat intermit-

*See page 277.

tents with chloroform. It was also tried on remittents, but failed. In chronic intermittent fever, the best treatment seems to be iodine and arsenic. The combination of iodide of iron and arsenous acid is often sufficient, without resorting to anything else. In chronic remittents, strychnia, quinine and piperine answer very well.

Dr. Wm. T. Taylor.—In this city I have noticed that where large building operations were going on, and cellars excavated, and the subsoil turned up exposed to the sun, malarial cases would develop.

My treatment has generally been large doses of quinia, and, as a rule, I have not failed. I give from fifteen to twenty grains, producing buzzing in the head. I believe that one large dose will do more good than small doses from time to time. Although afterward I may continue the remedy in moderate doses, yet on each septenary I give a full dose. Where they are indicated, I also use arsenic and iron.

Dr. J. W. Holland.—From what I have heard to-night, I should infer that I have come from a more malarious region than you have here, although my personal experience had led me to believe that Philadelphia was malarious, as well as other places.

In regard to diagnosis, I think that the position that periodicity is the best marked characteristic, is a safe one. Of course this is not absolute, for periodicity marks many forms of disease, and, in fact, it marks health. In the West and South, we find that diseases which are not at all allied to malaria show this periodicity very early; and in most acute cases occurring in these regions, some indication for a large dose of quinine will be found before the case has terminated. Experienced practitioners are apt to use thirty grains of quinine within twenty-four hours, at the beginning of such diseases as pneumonia, rheumatism, etc.

Dr. James Tyson.—I wish to say a few words with regard to the hypodermic use of quinine, in obstinate malarial affections. I formerly feared to use the salt in this manner, because of a horror of abscesses, and never did use it freely until a year ago, when I was forced to try it, by the failure of other methods of administration to break up an intermittent of one month's standing. I found by experiment that one drachm of water would dissolve seven and one-half grains of the bisulphate of quinia. The Pharmacopœia says it is soluble in the proportion of 1 to 10, the sulphate 1 to 740, the hydrochlorate being soluble in the proportions of 1 to 34. I began the treatment by the injection of this quantity (7½ grains) night and morning. In two days the paroxysms of chill and fever disappeared, and did not return. There was no more irritation than follows an ordinary hypodermic injection. Since then, I have used it more freely, not only in malarial cases but in other cases, especially where an antipyretic effect was desired. I have never had an abscess from it.

Dr. Meigs.—At the Pennsylvania Hospital, where we have patients from all parts of the country suffering with malarial diseases, I have found that it is seldom necessary to give more than sixteen grains in twenty-four hours, and this quantity is administered in four grain doses. When the diagnosis is positive that the intermittent disease is of malarious origin, this dose of the drug rarely fails to arrest the paroxysm, and the patient seldom has more than one chill after coming into the hospital. The circumstances are different, to be sure, when the patient is removed, for the time, at least, from the malarious influence, from what obtained in more highly malarious regions.

Dr. Carl Seiler.—There is one point in regard to the admininstration of quinia which might be mentioned. I have found that the taste of quinine can be almost entirely disguised by mixing it with an equal quantity of extract of glycyrrhiza and powdered chocolate. This is placed, dry, on the tongue, and washed down with a mouthful of water. About the only taste noticed is that of chocolate. Dr. Cohen is, I believe, in the habit of giving quinine in strong, black coffee.

Dr. S. S. Cohen.—I have little to add, but in reply to Dr. Wilson I would say,

with reference to the analysis of cases, that this has been more the force of repeated observation than of preconceived theory. My object was to try to find out why it was that a remedy which was of service with one man failed with another; and giving all doses promiscuously, it was at first a mere matter of accident which individual received a particular remedy. The system of classification which grew out of happy accidents is merely suggestive and not intended to be adhered to on strict lines. I believe the surroundings, and physiological and pathological antecedents of the patient, greatly influence the particular train of symptoms developed; and thus it is, after all, only suiting our remedy to the patient as well as to the disease. Had I thought that so much time would have been alloted to this subject, I should have endeavored to have brought forward facts in support of the suggestions presented.

The difference between malaria of different localities is quite marked. Though I have not practiced in the West or South, I have seen many instances of marked malarial cachexia in the practice of my preceptor, in patients who have been sent to Philadelphia from the West and South, for advice in other connections. At the Jefferson Clinic our malarial patients come from "The Neck," from Kensington and Richmond, and Manayunk, from New Jersey, Maryland, and Delaware.

I recall a case from Delaware, in private practice, in which phthisis was suspected. Examination of the lungs revealed no physical signs of such a condition. There was feeble respiration, the patient had a little cough, was run down, and anæmic. On studying the case a marked periodicity was noticed. The patient was ordered to a mountainous region, and while there developed a frank intermittent. This yielded to quinine. The patient returned to the city and was again seized with irregular manifestations, and under salicylate of cinchonidine and iodide of arsenic, is recovering.

I have been much interested in the remarks of Dr. Holland and Dr. Tyson with reference to the hypodermatic injection of quinine. I have had no experience with the bisulphate hypodermatically. Before resorting to the use of the bimuriate of quinia and urea, I had seen it successfully used as stated by Dr. Collins, in the German Hospital. I do not use it as a routine measure, or where the patient can be readily brought under the influence of quinine by the mouth. Used in the manner I have described, with the application of iodine around the point of puncture, I have thus far been lucky to escape ulcers, though sore arms resulted in the first two cases in which I employed it. I have seen abscess, however, even when due care has been taken. For poor people, the difference in cost between a long course of quinine sulphate and a few injections, costing less than ten cents each, of the bimuriate, is quite an important consideration.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING, JUNUARY 25TH, 1886.

The President, Dr. W. F. A. KEMP, in the Chair; J. M. HUNDLEY, M.D., Secretary.

PISTOL WOUND OF HEART, WITH SPECIMEN.

Dr. S. V. Hoopman exhibited the heart of a man shot at a distance of eight feet. The pistol was of the "Bull Dog" pattern, 38 calibre. The ball entered the fifth rib, near its costal articulation, passing through pericardium into left ventricle, entering it obliquely and coming out about two inches from point of entrance, producing a furrow in its muscular substance united by the points of entrance and exit. After emerging from the heart it passed through the lower lobe of the left lung and embedded itself in the soft tissues of the back, an inch or two to the right of of the spinal column. From such a wound one would suppose instant death, but the man lived nineteen hours. At first unconscious, reaction came on after use

of stimulants, &c. Dr. Hoopman called especial attention to size of the ball and length of time the man lived. Death was due to hæmorrhage in left pleural cavity; there was little in the pericardium and none from mouth. The reason the man lived so long, he thought, was the oblique manner the ball entered the heart, making a flap-like entrance and exit, and the heart, in its contraction, forced these down, covering the wound, thereby preventing full and rapid hæmorrhage.

Dr. H. F. Hill asked if hæmorrhage in pleural cavity came from the heart.

Dr. Hoopman thought it did.

Dr. J. E. Michael said he was called in consultation to see the case; found the man suffering from severe shock; gave stimulants and brought about reaction. He improved so much that he could answer questions, and said he knew he was mortally wounded; complained of severe general pain, which was relieved by morphia hypodermically. He said blood would ooze or spout from wound synchronous with respiration, and corroborated what Dr. Hoopman had said as to ball, its passage, &c.

Dr J. W. Chambers said this case was important, as showing us how long one could live with heart wound, and there was a possibility of one recovering from such. Shock, he thought, was the immediate cause of death, and not hæmorrhage, in most of the cases. An interesting fact was the ball making its way through the rib without fracturing it.

Dr. E. G. Waters cited several cases of heart wound. In one, the ball entered the cavity of heart and remained, patient living some time. Another of lance wound: In this case the lung and liver both were injured, and man lived six months and died of pneumonia. Said he had noticed a peculiar film sealing up wounds of vessels, and cited one of his own cases in which the bronchial artery was wounded. This *film* sealed up the wound and the patient got along well for ten days, when it gave way, necessitating ligation of vessel.

Dr. John Morris also gave several cases of wound of heart. The first was from large needle being driven into the heart; death instantaneous. The other was stab wound of ventricle, two inches in length, and man lived twenty minutes.

Dr. Michael differed with Dr. Chambers as to shock being the cause of death in most instances; no doubt it aided, but hæmorrhage was oftener the cause—first, from its general effect; second, acting mechanically, being poured out in the pericardium it hampered the heart in its action.

Dr. Hoopman said he had made twenty post mortems, and whenever a ball entered the rib it was invariably fractured, same in this case.

Dr. Ellis said reason rib wasn't fractured was due to velocity of ball.

Dr. Michael agreed with him as to its general application, but in this case the ball entered spongy portion of rib which would hardly fracture had the distance been much greater.

Dr. J T Smith then read a paper entitled

USE AND ABUSE OF ANTIPYRETICS.*

DISCUSSION.

Dr. A. B. Arnold said he did not believe any good physician would abuse any remedy. If antipyretics were abused he did not know it. When he saw fever he treated it; if high and bad pulse he reduced it. We can't reduce it permanently, but that is no reason it should not be treated. Antipyrin is a most excellent remedy.

Dr. I. E. Atkinson said there was a tendency now to go to extremes in treating fever. Especially is that the case in Germany. In measles, for instances, we have a temperature of 102° or more. It usually called for no treatment, provided the general condition was good. In Germany such amount of fever was actively treated. The temperature in ordinary cases of typhoid fever seldom called for special treatment; the general condition had better be looked after. In hyperpyrexia he thought antipyrin and all antipyretics good. He did not think thallin, kairin and resorcin of much

*See MARYLAND MEDICAL JOURNAL, January 30th, page 258.

value. While antipyrin was a most valuable remedy, it was not free from danger and inconvenience. He gave the preference to *cold water* when used with care and judgment. In its use we knew what we were doing; with internal remedies we did not. Antipyrin he considered an excellent remedy in the hyperpyrexia of sun stroke.

Dr. Smith closed the discussion, and said he was sorry his paper was misunderstood. While admitting the great value of antipyretics when properly used, he was sure they were much abused, and that fever should only be kept in bounds.

Dr. G. B. Reynolds exhiblted a specimen of

A RED FŒTUS.

supposed to be about 7½ months, but no larger than an ordinary fœtus of 8 months. Mother healthy, and has other children. Couldn't account for its color; mother felt it quicken when 5½ months pregnant.

Pilocarpin in Puerperal Convulsions.—Dr. G. T. M'Keough describes three cases of puerperal convulsions in which pilocarpin was exhibited, and draws the following conclusions in regard to the use of this drug:

"When the coma is profound, and has almost extinguished the action of the reflex centres, pilocarpin is a dangerous agent, on account of the impossibility to the patient of getting rid of the enormous quantity of bronchial secretion and saliva which floods the respiratory passages; but in those cases in which the physician is called before the patient has many convulsions—when the poison has not suppressed entirely the action of the reflex centres—when the patient is partially conscious, probably restless, and moaning, or when convulsions have not occurred, but seem imminent,—it is my conviction that we have in pilocarpin a most valuable adjunct in the treatment of this dreaded disease."— *Canadian Practitioner*, January, 1886.

A Case of Asymmetry.—At a recent meeting of the Medical Society of London, a remarkable case of asymmetry was exhibited by Dr. Isambard Owen. The patient was a young woman in whom the two sides of the body were unequally developed. There was an obvious enlargement of the left malar bone, a very apparent dropping of the left inferior maxilla, and a distinct enlargement of the arm, which was a quarter of an inch longer than on the opposite side. The clavicles were equal; the left hand and foot were larger, the latter measuring five-eighths of an inch more than the right foot. The left inferior extremity was one inch and an eighth longer than the right. The median line of the skull was not displaced. There was very little cranial deformity; some fullness at the point where the left parietal bone articulated with the temporal. The left ear was longer than the right. The chest was irregularly distorted, the left side being smallest above and largest below. The veins in both legs were varicose, more so on the left side. The patient stated that the malformation was congenital.—*Brit. Med. Journal.*

New Antiseptic Dressing for Use in the Field.——Desquin has recommended a very compact, simple, and cheap antiseptic dressing for use on the battlefield. It consists of filter-paper, sterilized by a prolonged heat of 248° F., which is then immersed in any desired antiseptic solution, and slowly dried. Seven or eight layers are applied to the wound, covered with gutta-percha, and held in place by a few turns of roller-bandage.—*Revue de Therapeutique*, December 15, 1885.—*Exchange.*

Powdered Rice as a Styptic.—According to the *Indian Medical Gazette*, powdered rice is stated to have marked hæmostatic properties. Mixed with lint, in proportion of from four to eleven per cent., the lint thus treated being used as a compress, it is more effectual than oxide of zinc, subnitrate of bismuth, salicylic acid, or carbolic acid.—*N. Y. Medical Journal.*

MARYLAND MEDICAL JOURNAL

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BALTIMORE, FEBRUARY 6, 1886.

Editorial.

DISARTICULATION OF THE HIP.—Modern surgery has made a decided impression on the results of this tremendous operation. Improved methods of operating, as well as greater familiarily with and more complete reliance on antisepsis, have transformed the exciting "performance" in which the patient was almost certain to be sacrificed, into a much more commonplace surgical procedure in which his chances for life are greatly improved. The appalling hæmorrhage and great shock which followed the older flap methods led to the modification of tying the femoral artery through a longitudinal incision, as the first step in the operation, after which amputation through the thigh was done and the femur subsequently disarticulated. In 1879, Koenig pointed out the possibility of turning the incision for resection of the hip into an oval amputation. In March, of the same year, Mr. Furneaux Jordan made his great modification which consisted in disarticulating the bone through the longitudinal incision and subsequently dividing the soft tissues of the thigh. In addition to giving the operator better control of the hæmorrhage and furnishing a better stump, Mr. Jordan's operation has the very great advantage of turning the wound away from the anus and genitals and thus, to a great degree, facilitating its antiseptic treatment. Many devices have also been introduced for the purpose of controlling the bleeding during the operation, among which the abdominal tourniquet, Esmarch's bandage applied in several ways, Davy's lever which acts through the rectum, and the transfixion rods of Newman and Trendelenburg are the most important. Little or no success has, however, been obtained by the various efforts in this way of leaving a stump, on which an artificial leg could be worn. Volkmann's direction to exarticulate sub-periosteally in order that bone might form in the stump, has been carried out with very imperfect success, as far as the production of a useful stump is concerned. Patients who have been successfully operated on continue to prefer crutches as a mode of locomotion. Mr. C. B. Keetley, of London, proposes (*Annals of Surgery*, December, 1885), a new modification of the operation, where it becomes necessary on account of morbus coxæ based upon "*the desirability of obtaining a stump which will permit the wearing of a useful artificial limb.*" His plan of action is derived from the following considerations.

1. Even after subperiosteal disarticulation, the patient seldom or never uses the artificial limbs provided for him, the stump being practically as useless as after flap operations.

2. However far down the shaft of the femur the disease may have extended, it is generally confined to the medulla.

3. The entire medulla may be safely removed from the shaft of the femur and the cavity treated with powerful germicides.

4. If in a case of exarticulation of the hip, the operation be devided into two parts, done on separate days, so that the patient have time to recover from the shock of one before the other is inflicted on him, he will be more likely to survive than if the total shock is given at one operation. Mr. Keetley, therefore, first excised the trochanteric part of the femur and forty-eight hours later amputated through the femur at a point near the junction of the shaft and lower epiphisis, scraping out the medullary cavity of the bone and using iodoform freely. Unfortunately the patient pass-

ed out of Mr. K.'s hands after about two months, having in the meantime suffered from an exhaustive diarrhœa, and subsequently died, not, he thinks, as a result of the operations. Hence he could not carry out his complete plan which was by plaster of Paris fixation during the healing process to obtain a stump on which an artificial limb could be used. It is doubtful whether a useful stump can be obtained in this way since all the normal muscular attachments are interferred with, and the fibrous union of the piece of femur left to the acetabulum so uncertain, but the attempt is ingenious and commendable and it is to be hoped that Mr. Keetley, or some other operator, may ultimately be able to test the matter more satisfactorily.

The Cremation of Garbage.—The Sanitary problem in reference to the removal of garbage seems to be in a fair way of a satisfactory solution. It has hitherto been the custom in many of our cities for men who keep pigs to contract for the removal of garbage which they used to feed to the pigs; but it has come to pass that the sanitary authorities have wakened up to the fact that the keeping of pigs in close proximity to the habitations of men was a nuisance, prejudicial to public health, and the fiat has gone forth that such nuisances must be abated. But what to do with the garbage, it would cost too much to haul it away off to the country. Burn it, says the sanitarian, and it looks as though the day were not far distant when furnaces for this purpose will be erected in all of our cities.

There are several varieties of furnaces that have been in satisfactory use in England, but it would seem, after careful examination, that the furnace built on Governor's Island, New York, from the plans of Lieutenant Reilley, of the Army, is the best. This furnace costs only three hundred and fifty dollars, and consumes all the garbage of the garrison. The great point in favor of the Reilley furnace is that no fuel is required, the garbage serving as the fuel to burn itself. At first a fire is made with coal and wood, and the garbage is placed in a chamber on the side, where it is dried and made combustible; the next day it is pushed over into the fire, while a fresh lot is put on the side to dry, to be in turn burned the next day. Thus a continual fire is kept going from the combustion of the garbage. For a city like Baltimore, probably thirty or forty such furnaces would be required.

Miscellany.

Albuminuria Treated by Fuchsine.—Mr. A. T. Barnard reports the following case, which came under the care of Mr. W. Mitchell Roocroft. Wm. R. aged 40, was admitted to the Royal Albert Edward Infirmary, Wigan, on May 8, 1885. There was extreme anasarca of the head, face, and legs, and ascites; the tongue was coated, the breath very foul, and the skin hot and dry. On inquiry, he said he had been working for some time in water in the pit. He complained of pain in the lumbar region. The urine, on examination, was of a pale straw color, and acid reaction, of specific gravity 1015; there was a slight deposit, and it became almost solid on boiling; under the microscope, granular casts were found. The quantity of urine passed was three to four ounces on the day after admission. The following treatment was adopted: a vapor-bath was to be taken three times a week, and a drachm of compound jalap powder every second morning. He was ordered: R. Tinct. digitalis mx; tinct. ferri perchloridi mx; aq. chloroformi ad ℥j; to be taken three times a day. His diet was ordered to consist solely of skimmed milk, eight pints daily.

This treatment was continued until July 16, with the exception that jalap powder was discontinued on June 15. During this period, the ascites and anasarca diminished, the amount of urine passed daily varied between sixty and seventy ounces, the amount of albumen also varied between one-half and one-third.

As he did not seem to improve under this treatment, a grain of fuchsine (in

the form of pill made up with compound tragacanth powder and extract of gentian) was prescribed to be taken three times a day, and he was allowed ordinary diet.

On July 20, the dose of the drug was increased to two grains three times a day, the amount of albumen when the fuchsine was commenced being one-third the urine containing crystals of uric acid and waxy casts. The urine (owing to the drug) now assumed a pinky-red color, and the fæces were also colored.

In ten day, the albumen was reduced to one-sixth, and on August 13, there was a mere trace, which continued until he was discharged (at his own wish),and made an out-patient, still continuing the fuchsine, which was now reduced to three grains in the day.

His urine was examined every week or ten days, and on the last three occasions there was a total absence of albumen, and nothing microscopically, the fuchsine being reduced to one grain the day.

On September 30, the patient was discharged, and intended to recommence work.—*British Med. Jour.* Dec. 5. 1885.

Faradic Electricity in Rigidity of Os Uteri During Labor.—In the *American Journal of Obstetrics* for January, 1886, Dr. Mary Putnam Jacobi reports the following interesting case:

A primipara was brought during a premature labor, occuring at seven months of pregnancy, to the N. Y. Infirmary in a state of considerable exhaustion resulting from the prolonged labor-pains. The external os was tetanically rigid. I did not see the patient until after she had been some time in the hospital, and the physicians in charge, Drs. Blackwell and Cushier, had used all the most usual and approved means of relaxing the rigidity of the os, but without the slightest effect. Even chloroform had failed, and the increasing exhaustion of the patient rendered this method hazardous to be persisted in. It seemed to me that the tetanized condition of the os, which would barely admit the tip of a finger, and resisted manual dilitation to an extraordinary degree, was precisely due to the exhaustion of the nerve force destined to the uterine fibre. The tetanus would then be analogous to the intestinal cramps of lead colic; to those induced in both the rectum and the genital canal by compression of the aorta (in rabbits) or, on an even more general scale, to the universal muscular contractions of rigor mortis. If this were true—and surely the clinical history of cases of rigid os uteri tends to support the hypothesis—local stimulation of the exhausted nerve fibres was indicated as the remedy. A small electrode was applied to the os, and connected with a faradic battery, the other electrode being held in the patient's hand. It was considered desirable to avoid passing the current through the body of the uterus, lest new contractions should be excited and struggle in vain against an impassable resistance. The application was continued for fifteen minutes. Immediately afterwards, and for the first time, Dr. Cushier succeed in inserting a finger into the cervical canal, and after some further effort, in gradually effecting manual dilatation and delivering the patient with the forceps.

Stimulus to the nerve fibres thus seemed to have succeeded in inhibiting the spasm in which the muscular fibre had been thrown, as is habitual when left to its own irritability.

Brown-Sèquard's Mixture for Epilepsy.—

Iodide of potassium - -	8 parts.
Bromide of potassium -	8 "
Bromide of ammonium -	4 "
Bicarbonate of potassium	360 "

Dissolve. A teaspoonful before each of the three principal meals, and three dessertspoonfuls on going to bed. The solution should be given diluted in cases of idiopathic epilepsy.

If the pulse of the patient be feeble, the potassium bicarbonate is replaced by ammonium carbonate, while for the 360 parts of infusion of calumba there are substituted 90 parts tincture of calumba and 270 parts of distilled water.—*L' Union Médicale*, December 31, 1885.—*Med News.*

Cancerous Cachexia.—Dr. Goodell says it is a great mistake to suppose that the cancerous cachexia is present in every instance of cancer of the uterus. He thinks that it is absent in about one-half the cases which come to him for treatment. Instead of being lean, bony and scrawny, with a leaden hue of the countenance, many of the cases present a buxom appearance with rosy cheeks. These cases, according to his observation are less amenable to treatment and are less benefitted by operative influence than are those in which cachexia is apparent early.—*Med. Bulletin.*

A Physiologist's Will.—On the first page of the will of the late Prof. Robin is the following request to the heirs:

"If I die in Paris, let my autopsy be made at the earliest possible moment after my death, by one of the prosectors or assistants of the École de Mèdecine, to be designated by the Dean. My brain and eyes should be removed and studied comparatively. The left eye was destroyed by a blow in 1835, and the optic nerves and convolutions should be studied with this fact in view."—*Med. News.*

Potassium Salicylate in Acute Rheumatism.—Dr. E. L. Miller, of Eaton, N. Y., recommends the use of the potassium instead of the sodium salt of salicylic acid in acute rheumatism. He claims that the potassium favors the elimination of the worn-out albuminoid products which fall short of being converted into urea in the body; he has used this salt when the stomach refused to tolerate the sodium salt.—*Cincinnati Med. News*, Dec. 1885.

Strychnine in Acute Alcoholism.—Lardier (*Jour. de Med. et de Chir. Practiques*, June, 1885; *Practitioner*, December, 1885) has long employed strychnine in the treatment of delirium tremens for which he regards it as a specific. He insists upon the use of large doses. In one case he had for several days given $\frac{1}{15}$ grain every two hours without any appreciable result. He then increased the amount, part of which he gave hypodermically, giving in all $1\frac{2}{3}$ grain in twenty-three hours. The patient soon fell into a refreshing sleep, and there was not the slightest symptom of strychnine poisoning.—*New York Medical Journal.*

Blood-letting in Erysipelas.—Dr. Daniel Lizzaralde, of Buenos Ayres, stated that he has seen most excellent results following the abstraction of blood in facial erysipelas. The procedure is indicated in the case of a strong, full-blooded adult, when the temperature is high and the cerebral symptoms are threatening.—*Med. Record.*

New York Physicians Seeking Protection.—Drs. E. G. Janeway, A. Jacobi, Austin Flint, and twenty other physicians, have sent to the Board of Health a written protest against the liability to suits for damages which physicians are made to assume when in good faith they report supposed cases of contagious diseases. A recent suit against a physician, who reported that a woman had smallpox when she was suffering from another disease, was the cause of the protest. The Board was urged to prepare a bill for the Legislature to exempt physicians from the legal consequences of too hasty reports in cases of suspected contagion.—*Med. News.*

Suppository for Hemorrhoids.—Martin recommends the following formula for use in cases of hemorrhoids:

Antipyrin	-	38 grains.
Cocoa butter	-	150 grains.

For five suppositories: two or three every twenty-four.—*Revue de Thérapeutique*, Jan. 1, 1886.—*Med. News.*

Trephining for Epilepsy.—At a late meeting of the Nothumberland and Durham Medical Society, Dr. Oliver showed a boy who had been trephined in the right parietal region for supposed traumatic epilepsy. The fits had developed after a blow on the head; and although, on admission to the Newcastle-on-Tyne Infirmary, no injury could be detected, it was decided to trephine, as the epileptic phenomena were unilateral. The opening was made an inch above

and behind the right ear, and a quantity of effused serum and lymph removed. The wound healed well, but the fits continued, though with less severity and frequency.—*British Medical Journal*, January 2, 1886.

Medical Items.

Burlington, Vermont, has long enjoyed the reputation of being one of the healthiest cities in the United States. In keeping with this record, the Health Officer reports but one death in that city from infectious disease during the month of December, 1885.

The Female Physicians practicing in Paris, are now eight in number.

A Bill to Regulate the Practice of Medicine in the State of Maryland will be presented to the Legislature during its present session by a committee appointed by the Medical and Chirurgical Faculty of Maryland. The full text of this bill will be printed in the next issue of this JOURNAL. We understand a similar bill has been presented to the Legislature by the Alleghany County Medical Society.

THE DOCTOR AHEAD.—"If I were so unlucky," said an officer, "as to have a stupid son, I would certainly make him a doctor." "Well," said a doctor, who was in the company, "you think differently, sir, from your father."—*Medical Record.*

The *N. Y. Medical Journal* relates the following amusing incident in a malpractice suit recorded by the St. Paul "*Pioneer Press.*" The plaintiff, being on the stand, was asked by his counsel, "How long was it after the operation before you regained conscientiousness?" The witness hesitated in order to give his attorney an opportunity for correcting his question, but it was not improved, and the defendant is sure that "conscientiousness" has never been regained by the plaintiff.

Dr. Mathias Duval is announced to be the successor to the late Professor Robin.

M. Germain Sée has recently detailed the results of a number of experiments made upon the human subject with sulphate of sporteine in doses of one and one-half grain. He concludes that the drug is indicated in all cases of yielding of the cardiac muscle, whether from alteration of its tissues or from extra work imposed upon it by an impediment to the circulation. He asserts that it will speedily improve the character of the pulse when it is weak, irregular and abnormally slow.

While the Drs. Purdy were fined $500 for reporting a case of small-pox, we learn that now Dr. Z. P. Dennler, of Long Island City, has been indicted and held on the charge of not reporting a case of small-pox. Verily, the doctor's position is not a pleasant one.—*Med. Record.*

Prof. Da Costa considers pelletierine, the active principle of the pomegranate bark, by far the best *tænifuge* we possess. In all his experience with the drug, he has known it to fail but once. His success is due in part to his plan of treatment, which is the following, given to a woman who had been passing tapeworm segments for *eighteen years:* At night, after twenty-four hours of almost absolute fasting, five grains of calomel are to be taken; on the following morning, one-half of the bottle of Tanret's solution of pelletierine, on an empty stomach, and two hours later the remainder of the solution. If free purgation does not follow, let the patient take pulvis jalapæ comp. ʒj.—*Col. and Clin. Record.*

For a marked case of *malarial cachexia*, with latent pleurisy, Prof. Da Costa prescribed the following:

℞.	Tinct. ferri chloridi,	f ʒ ss
	Acid. acet. dil.,	f ʒ iij
	Liq. ammonii acet.,	f ʒ ij
	Elixir simplic.,	f ʒ ix
	Strychniæ sulph.,	gr.ss. M.

SIG.—Dessertspoonful ter die, to be doubled slowly.

In addition, four grains of quinine, to be taken every morning *before* breakfast, directly after arising.—*College & Clin. Record.*

Original Articles.

THE PNEUMATIC CABINET AND PNEUMATIC DIFFERENTIATION.*

BY F. DONALDSON, JR., B.A., M.D.

Chief of Clinic for Throat and Chest, University of Maryland.

I wish to bring to your attention this evening the pneumatic cabinet and the principle of pneumatic differentiation as perfected and applied by Dr. Herbert F. Williams and Mr. Joseph Ketchum, of Brooklyn. The subject of the pneumatic treatment of lung diseases is an extensive one, with the history of which I shall not now trouble you, but would refer you to a brief and comprehensive paper by Dr. Hudson in the *Record* for January 9, 1886.

There have been many forms of apparatus for the use of compressed air in respiratory diseases, but the one most familiar to the medical man is the cylinder of Waldenburg, and as I find that the pneumatic cabinet is supposed by many to be simply a modification of that of Waldenburg, I have brought one of the latter here to-night. As you see it consists of one cylinder, with its open end downward immersed in water, within a second or larger cylinder. By a system of cords, pulleys and graduated weights the upper cylinder may be lowered or raised and the contained air condensed or rarefied. Connected with the interior is a tube with mouth-piece which fits tightly over the patient's mouth and nose. In determining the indications for pneumatic treatment in different chest diseases Waldenburg was "guided by the causes of dyspnœa, whether the product of inspiratory or expiratory obstruction, or of both;" for instance, he concluded that in emphysema retarded expiration was the immediate cause of the dyspnœa and in phthisis that inspiration was chiefly impeded; and he made the patient inspire condensed air or expire into rarefied air, as the condition demanded. Both these methods were found to give considerable benefit when properly employed. In this apparatus, I would beg you to note that the increase or decrease of pressure is exerted upon the *lungs only;* that the amount of pure air is very limited, the patient constantly rebreathing the air in the cylinder, and that there is no possibility of medicating the air or of using a medicated spray or vapor. Modifications of the above apparatus have been employed by Cube, Schnitzler, Bierdert, Frankel, Oertel, and by Geigle and Meyer. Another method for the pneumatic treatment of respiratory diseases is by means of the *Air Bath*; this method is greatly in vogue on the Continent of Europe, where, according to Dr. Theodore Williams, fifty such establishments exist. These air baths are of various sizes and dimensions. They consist, speaking generally, of a chamber capable of holding one or a dozen people, so constructed that a person may spend days in them. Connected with the chambers is an apparatus for compressing or rarefying the air in it. The atmosphere of course can be changed at will, or impregnated with what medicament you choose. Dr. Theodore Williams has one of these chambers in constant use in the Brompton Hospital, London, and certifies to its great usefulness in the various forms of lung diseases, anæmia, amenorrhœa, chronic catarrh of the ear, etc. This form of apparatus has the manifest disadvantage of great cost and size, and though the atmosphere may be medicated, there is no means by which we can direct a medicated spray or vapor directly and with force into the lungs.

As for the various forms of oro-nasal, and oral inhalers now in use, we know how beneficial they may be in pharyngeal, laryngeal and bronchial troubles. Of how little practical use in diseases of the lung aveoli themselves. The respiratory power in the very persons who are generally considered subjects for the inhalation treatment, is, as a rule, much impaired and their inspirations so weak and shallow that little, if any of the medicament used is drawn into the lungs.

*Read before the Clinical Society of Maryland, Feb. 5th, 1886.

There are many other objections to be urged against the above methods, all of which are met in the form of apparatus which I am about to describe. The following description of the cabinet is taken verbatim from a paper by its inventor, Mr. Ketchum. "The instrument in question is a cabinet of proper size and shape to hold a man in the sitting posture, and rigid enough to withstand the superficial pressure when rarefaction is produced inside; strong enough to stand the jars and jolts of transportation. It is made of steel sides, bottom and top fitted to wrought iron angle frame, with a heavy glass front and a door in the rear, air-tight when closed but capable of being opened at an instant's notice. In front and below the glass is a projection which sustains the atomizing apparatus and medicine receptacle. In the centre of the glass an aperture is pierced through which the breathing-faucet penetrates far enough into the cabinet to allow a soft rubber breathing-tube to be slipped on. The breathing-faucet is constructed of hard rubber, and is of such shape and design that when in use the condensate collecting in it on the patient's side of the stop-cock flows out through a drip-hole in the latter, while the condensate formed in front flows back into the medicine receptacle and is re-used. At the side of the projection is another stop-cock entering the steel front of the cabinet, used for decreasing the rarety or pressure inside the cabinet without removal of the breathing-tube from the mouth of the patient. In front and immediately over the glass is a manometer gauge connecting with the interior of the cabinet, filled with mercury to the zero point and graduated to $\frac{1}{10}$ inches. On the top or roof is a bellows whose interior capacity is approximately one-thirtieth of the cubic capicity of the cabinet. The interior of the bellows, by a valve in its floor, communicates with the interior of the cabinet. This valve is operated from the inside of the cabinet. The bellows communicates with the outside air by another valve in its upper side operated from the rear of the cabinet. The bellows is operated by a rock-shaft running across the top of the instrument supported by shaft standards on each side, and to one end of which an operating lever is keyed. The saturation of the air is accomplished by the use of an atomizer and stand operated by compressed air or steam, and of such height as to deliver its spray directly into the mouth of the breathing-faucet.

The method of administration is so simple that, under the general instructions of the physician as to medication, length of time, and amplitude of force as indicated by the guage, it can and has been satisfactorily used by the invalid's ordinary attendant.

The patient is first instructed in the method of respiring entirely through the mouth, and is told that while the air will flow down into the lungs without any effort, a slight blowing force will be necessary to expel it preparatory to the next inspiration.

He is next told that when the air of the cabinet is rarefied he may experience a slight swelling of the tympani, and to relieve which he is instructed to swallow, thus opening the meatus of the Eustachian canal, and allowing sufficient of the air enclosed to flow into the throat to produce equilibrium with the surrounding atmosphere. He is next seated in the cabinet on a chair adjustible for height, and raised or lowered until his mouth is on a plane of slightly higher elevation than the opening in the glass front, and a clamp is placed on the external nares to prevent the escape of air by that channel. The door is now closed, the valve-rods having previously been placed to indicate that the valves are set to produce rarefaction; the operator passes to the front of the instrument and, having closed the breathing and auxiliary faucet, with his eye on his gauge, moves the lever operating the bellows toward the rear with a slow, even motion, until the difference between the levels in the two arms of the manometer indicates a rarefaction of, say, from one and a half to two inches.

The object of this procedure, before beginning the treatment proper, is to expand the residual air in the lungs, and if any has been imprisoned behind mucus,

or catarrhal plugs, or infarctions, to exert a pushing influence from behind and toward larger bronchi, and produce ultimate evacuation."

"The rarefaction is now allowed to run down by the use of the auxiliary faucet until the manometer indicates the amount deemed proper by the attending physician, and the spray having been adjusted to the breathing-faucet and turned on, the patient is instructed to take the breathing-tube and place the mouth-piece with which the end is fitted in his mouth, in front of and against his teeth, enclosing the rim with his lips to prevent displacement by the interior pressure. The stop-cock is slowly turned on. Nature asserts herself, and the inflation of the cheeks and rise of the thoracic envelope indicate that the restraint first offered by the stop-cock is now offered by the cell-walls, and the same influence that is distending the cheeks so markedly is distending the alveolar walls.

This first inspiration has distended every cell and avenue, and the process of diffusion with the air charged with vapor of the medicament proceeds with a rapidity commensurate with its enlarged avenue of approach, and the act of expiration commences. This is brought about by the patient's forced muscular expiratory effort, and the pressure of the cell-walls on the loaded air reduces its hydrometric condition to a point where condensation is effected exactly in proportion to the energy of the effort, minus the effect of the increased temperature. Subsequent respiration is no greater in amplitude than normal, except in so far the feeling of inflation may induce a greater expiratory effort; but after a time the patient becomes fatigued, notwithstanding frequent rests (during which he respires the air in the cabinet), and the expiratory act becomes labored. The door is now opened and the valves, inside and out, are set for vibration of the enclosed atmosphere synchronously with the respiratory act from plus to minus, the weight of the outside air. In other words, the top valve is closed and the bottom one opened wide. The door is again closed, and the breathing-faucet is opened, and with the lever the bellows is raised until it has reached an elevation equal to one-half its height, and the patient is instructed to again place the tube in his mouth and make his first act one of inspiration. At the same time the operator raises the bellows to its full height and holds it during the interval preceding the expiration. Then, allowing it to descend to the midway point, he forces it to complete collapse, thus compressing the air to the extent of one-half the contents of the bellows, and by this compression forcing the collapse of the thoracic walls and consequent compression and condensation. This method continues,if used as a pulmonary calisthenic, or as a "means of topical application of remedial agents," until in the judgment of the operator the dose or exercise is deemed sufficient. The influence of compressed air surrounding the patient while he is breathing at normal density, of course exerts its influence in a contrary direction, except in relation to condensation, where the outflow of air is retarded by the constricted condition of the glottis during expiration (Dalton, p. 233). This anatomical verification of the conclusion arrived at, independently, by logical deductions from the action of the manometer in estimating the dynamic value of expiratory energy, is as welcome as it is conclusive."

Such being the construction of the cabinet, it will be seen that it can be put to the same uses as the various forms of apparatus we have mentioned. The method of treatment, however, by this cabinet is entirely different from any ever used before, viz: 1st, the diminution of atmospheric pressure on the thoracic walls and peripheral parts and the forcible inhalation of comparatively dense medicated atmosphere; 2d, the increase of pressure on the body generally and forcible expiration into comparatively rarefied air; 3d, and most important, the alternate rarefaction and compression of the atmospheric pressure around the body,and the consequent involuntary increased inspiration, and expiration.

It might be well, just here to answer

an objection which may be raised in the discussion of this paper, that no amount of spray will be carried to the person's mouth, through such a comparatively small opening as that in the stopcock. I have tried the experiment and find that with twenty-five pounds pressure a large spray was projected about three feet from the opening into the cabinet.

What is the result when we rarefy the air in the cabinet? We remove pressure from the body generally, the chest walls expand and the capacity of the lungs is increased, while the inspiration of the relatively dense air outside dilates the bronchi and vesicles, opens contracted tubes and atelectacic alveoli; and to put it simply, we compel the patient to take an extraordinarily long and deep inspiration.

It has been found that the amount of air, inspired at a vacuum of $\frac{1}{30}$, of an atmosphere, was increased from 20 to 100 per cent., with of course a considerable increase in chest measurement. I found in my own case that outside the cabinet my chest expanded from 33½ to 37, while inside the cabinet with a rarefaction of $\frac{3}{10}$ of an inch of barometric pressure, or about $\frac{1}{100}$ of an atmosphere, I expanded to nearly 39 inches; an increase you see of nearly two inches. The greater expansion of the chest having been proved then, what is the physiological effect of so long and deep an inspiration of a comparatively compressed atmosphere. To tell the truth we are not at present in position to answer this question, for as yet no satsifactory physiological experiments have been conducted under these conditions. Speaking generally, however, we may state that the aspirating power of the thorax is much increased, the pressure within the thorax becomes less than normal and there is a corresponding increase of venous blood flow into the right heart; a greater amount of blood passing to the left heart and a corresponding increase of arterial pressure results. The pulse rises from 70 outside to 80 inside the cabinet. We are somewhat in doubt as to the effect, of so great an increase of the respiratory movements as we have under these conditions of rarefaction, on the capillaries of the lungs themselves; and it is an important consideration in view of the possibility of producing hæmorrhage. I have been asked whether the inhalation of comparatively dense air with greater expansion of the chest, would not particularly in weak chests, tend to produce hæmorrhage from rupture of the alveoli and smaller capillaries. It is held by some physiologists that the increase in the area of the wall of each pulmonary alveolus tends to stretch and elongate the capillaries lying in the alveolar walls, and in elongating, necessarily narrows them. This very narrowing of the capillaries presents an obstacle to the passage of blood through them.

Again, the rarefaction of the air removes pressure from the peripheral vessels and tends to draw blood from viscera and thorax to the surface and consequently to lower capillary pressure in the lungs. Both these facts would seem to show that the tendency to hæmorrhage would be diminished and not increased; of which point indeed Dr. Williams claims to have abundant clinical proof. As to the possibility of the deseased alveoli being torn by the increased pressure, it was found that no such results followed the use of Waldenburg's method where the increase was from $\frac{1}{59}$ to $\frac{1}{40}$ an atmosphere, whereas in the cabinet we use a fall of $\frac{1}{10}$ to 1 inch barometric pressure or a minimum rarefaction of $\frac{1}{300}$ and a maximum of $\frac{1}{30}$ of an atmosphere.

The next question of importance relates to the extent to which the medicated vapor or spray, used in this method, is carried into the ultimate alveoli of the lungs.

As we have shown the tidal air is increased by differentiation to 40 cubic inches, and the relation between the tidal and residual air has been changed from 1 to 10, to from 1 to 5, or from 40 to 200 cubic inches and a greater amount of diffusion in the interval between inspiration and expiration is the result. And so we see that the physical conditions of ordinary respiration are reversed. For instead of having as under normal conditions, 200 cubic inches of residual air diffusing its moisture into 20

cubic inches of comparatively dry tidal air, we have (owing to the inhalation of comparatively dense saturated spray) 40 cubic inches of tidal air diffusing into the residual air the moisture with which it is burdened.

Inspired air at 75 deg. F. has a tension of .733; when expired it is 90 deg. F. in temperature, and its tension has been increased to 1.410, that is, its capacity for water has been increased within the lungs; constant evaporation from the ærating surface is going on, which, according to Valentin, is about 1⅛ lbs. daily.

"It is therefore clear that, with any method applied under natural conditions respiratory air charged with moisture at a temperature below that of the lungs, not only retains its moisture during the complete act, but acquires an additional quantity by evaporation from the pulmonary surface, in exact proportion as the pulmonary temperature is imparted to the inspired air.

By what artificial aid can this process of evaporation not only be checked, but the natural process reversed, and the air compelled to deposit instead of acquire moisture when within the lungs?

The two conditions hostile to the deposit of moisture are the contrasted temperatures, and their variations of aqueous tension.

The former is beyond control, for no artifice can safely invade the lungs to sufficiently reduce their temperature.—We can, however, compel condensation, by inter-pulmonary compression, to an exent that will not only counteract the increase of tension, but will leave a margin sufficient to effect this condensation. If a lung is surrounded by an atmosphere equal to a barometric height of twenty-nine inches, while its interior is exposed to one of thirty inches, a differential pressure equal to one-thirtieth of an atmosphere is exerted against the walls; and to effect expiration this pres sure must not only be overcome, but muscular or other force must be exerted sufficiently to overcome its inertia, as well as the capillary and bronchial friction heretofore referred to as the second obstacle.

Manometric tests show that in respiration, under the circumstances stated, the expiratory effort is equal to a difference of 4.5 inches of the manometer, and that a pressure five and a half times as great as that at which air enters, is necessary to dislodge it. This increase in pressure reduces the carrying capacity, or hydrometric condition, and is equivalent to a reduction of temperature, and a resulting condensation of the vapor from the air respired.

The usual remoteness of lesions from the larger bronchi is observed, and the connection between the cause and effect springs into prominence. Having demonstrated that wherever saturated air penetrates, its physical properties can be so changed that condensation ensues, it only remains to prove that these localities are penetrated by saturated air, and the topical application is demonstrated. Spirometric tests show that, while tranquil inspiration amounts to from fourteen to eighteen cubic inches, the initial inspiration, aided by the differentiation of the breathing and the surrounding atmospheres, amounts to from twenty-eight to forty cubic inches, dependent upon the differentiation; and this excess over tranquil respiration must penetrate to regions only partly used, or entirely disused, in ordinary respiration."

We hold therefore that in this method not only is the elargement of the chest and the capacity of the lungs increased, so that the tidal air is increased fifty per cent., but also that tubes are distended, air sacs ordinarily inactive or but feebly expanded are brought into fullest action, increased oxygenation is produced blood more fully vivified and heart circulation stimulated, poorly developed, weak chests made stronger, pleuritic thickenings and adhesions stretched and broken bronchial workings, and contractions dilated. (Dr. Hudson.)

But in addition to all this we claim that the spray indicated is carried far into the lungs and deposited in the ultimate avleoli, and of this there can be be no doubt, for as as Dr. Williams says:

"Cinchonism has been produced by inhaling quinine; mydriasis by inhaling a solution of atropia. In using the mer-

curic solutions we found it necessary to restrict their use. In one case after three treatments specific symptoms appeared. An experiment upon a full-grown rabbit was made as follows: Tracheotomy was done without the use of an anæsthetic. A canula of one-tenth inch inside diameter was introduced and tied; to this a rubber tube one fifth inch in diameter and eight inches in length, was made to connect with the outside of the cabinet. An assistant held the rabbit in position, and a mixture of China ink and water was sprayed into the tube. The point at which the animal's ability to expire against the normal atmosphere was reached at seven-tenths of an inch; artificial expiration was resorted to, and the rarefaction was increased to nine-tenths of an inch. This was maintained for ten minutes. The spray was shut off, tube disengaged, and the rabbit allowed to run about the floor for ten minutes, which it did with no apparent discomfort. Its spinal cord was now ruptured and the lungs immediately removed.—Macroscopic examination shows pigmentation more marked at base of lungs, yet deep discoloration is seen at different points in the subpleural spaces on the periphery. Microscopic observation of fresh sections cut transversely from without inward from all parts of the lungs, shows abundant pigmentation in the ultimate alveoli. China ink was selected because of its utter insolubility, fineness of its particles, and the length of time which it will remain in suspension."

But as medical men you will say, the theory of this apparatus is all very well, but what are the clinical results of your treatment? I can answer with truth that they are entremely satisfactory. I am unable to give you a tabulated statement of a series of cases, but I can say that in several cases of more or less advanced lung diseases, there has been marked improvement, decrease of expectoration, lessening of cough, etc. In one case of asthma from more or less chronic bronchitis with some emphysema the relief was very great. I hope soon to be able to present to you a series of cases which may show in detail the results of treatment.

In January, 1885, Dr. Williams reported 11 recoveries out of 16 cases of primary tubercular infiltration and softening. Of these, five were in perfect health in September, 1885; one of these, a man had broking down and a cavity with emaciation and night sweats and who was treated two years ago, is now a strong healthy man and has lost but one day's work in 18 months.

Another who had had severe hemorrhages and bad cough regained his health and became a longshoreman. The remaining six are at last accounts in good health. Dr. Williams gives a long list of cases, including phthisis in all its stages, which showed a large proportion of marked improvement and cure. Dr. Jensen, of Chicago, has reported a number of cures of acute catarrhal phthisis, who were treated in the Ketchum cabinet; in all of the cases observed there was extraordinary and permanent relief. Dr. Houghton, of Chicago, also gives a long list of cases improved and cured,of phthisis in all its stages, of asthma and emphysema also, and I myself can testify to the wonderful effect of differentiation in an acute asthmatic attack. Finally the results gotten by this method are vouched for by Dr. Loomis, and Dr. Darwin Hudson, of N. Y., and many genlemen. Dr. Bowditch, of Boston, wrote to a friend that the pneumatic cabinet would work a new era in the treatment of lung disease.

Dr. Hudson says that in addition to its great use in lung troubles, "Many other therapeutic problems may be solved by the Ketchum Cabinet. The withdrawal of peripheral pressure favors elimination by the skin, relieving venous engorgement and vascular tension in the kidneys and liver and permits the depurative functions of these organs to be resumed, functions so often vitiated by interstitial deposit, increased by the obstructive changes in circulation within heart and lungs, or in common with them, the product of a rheumatic or gouty vice."

There are many other points of interest in connection with this method of treatment, to all of which I have found it impossible to call attention in this ar-

ticle. My father and I are using the Cabinet daily and will be only too glad to explain its workings and any points I may not have made clear. Finally, all we ask for this apparatus is a strict but unprejudiced investigation. It is not a toy, it is not an air bath, it is not a modification of Waldenburg's cylinder. It is a piece of strictly scientific apparatus, about whose workings there is neither guess work nor accident.

REMINISCENCES, HISTORICAL AND PROFESSIONAL.*

BY ALEX. H. BAYLY, M. D., OF CAMBRIDGE, MD.

The Baltimore Infirmary 1833-4.

I passed a year in this institution, corner of Green and Lombard streets, a small affair then, to what it is now. It was the very best building on Lombard street, all around and beyond being commons and country. It was also then used by the U. S. Government as a Marine Hospital, there being no other place for the accommodation of sick sailors. The number of students was limited to four, and my confrères were Samuel Geo. Baker, John C. P. Wedderstrandt and Thos. H. Healy, who, after graduation, became the leading physician of Cumberland, Md.

At that time, no pecuniary consideration was demanded from the student, his services being considered ample payment. Merit with proper influence received the appointment. The rules and regulations of the House were very stringent, one of us being required to be always present, and being absent without permission from the Sister Superior, two consecutive nights, rendered the one so offending amenable to suspension. We took our meals at some convenient place and slept in the house, and were required to be in before 9 o'clock, the house at that hour being locked and no admission granted but to the call of a patient.

Solomon Etting, Esq., a wealthy Israelite, was Governor of it, with almost absolute powers in the management of its affairs. Sister Ambrosia, whose name one of my daughters bears, was the "superior." Profs. N. R. Smith, R. W. Hall, Eli Giddings, Nat. Potter and Robley Dunglison, the visiting surgeons and physicians, all of them dead and gone and I alone left. But fresh and green is their memory and the recollections of those days are indeed most pleasing, yet not without sadness. It was to me, the happiest year of my life.

BALTIMORE, January 29th, 1886.

Editor of the Maryland Medical Journal.

MY DEAR SIR.—Having observed in your columns a remark of my friend, Dr. E. G. Waters, that Dr. Alex. H. Bayly, of Cambridge, Md., had resorted successfully, many years ago to the magnet in removing a spicula of iron embedded in the cornea, I wrote to that gentleman to get the particulars of the case, and received a full and satisfactory reply, giving not only that case, but several others of interest, and in fact, the venerable man believing (and justly) that he had in me a sympathetic listener, recalled many items in his long experience, with the *abandon* and freedom of the old veteran "who shoulders his crutch" and shows how fields were won. Believing that his letter contains much that would interest your readers I have ventured of my own accord to offer it for publication, condensing only where it could be done without marring the general tenor of its racy style.

For the benefit of those who do not enjoy his personal acquaintance, I would state that Dr. Alexander H. Bayly, son of the late Hon. Josiah Bayly, formerly Attorney-General of Maryland, was born March 3d, 1814, at Cambridge, Dorchester county, Md. At fourteen he entered St. Mary's College, Baltimore, where he was the classmate of the Hon. S. T. Wallis and Dr. Thos. H. Buckler, and the fellow student of the Hon. Robt. McLane, our present Minister to France. He left this institution in 1830 to enter Washington (now Trinity) College, Hartford, Conn., where he completed his studies in July, 1832. In September following he began his medical studies with Dr. Vans M. Sullivan, of Cambridge, and in the following May (1833) entered as pupil the office of Prof. Samuel Baker, who held the chair of Materia Medica, &c., in the Medical Department University of Maryland, until in the summer he resigned and was succeeded by Prof. Robley Dunglison. His fellow pupils here were the preceptor's son, Samuel George Baker, afterwards Prof. Materia Medica under the Regents, and John C. P. Wedderstrandt, subsequently Prof. Anat. and Phys. Med. University of Louisiana. He was Res. Student at the Baltimore Infirmary 1833-4; graduated M. D. at Md. Med. Univ. 1835, and soon after opened his office at Cambridge, when he at once entered into a very extensive and laborious practice, which he continued to pursue until within a few years past. For nearly 50 years continuously he was one of the Board of Medical Examiners for the Eastern Shore of Maryland, and for many years one of the curators of his county.

In 1862, he was Surgeon U. S. A. to Wallaces' and Wharton's Regiments. For 40 years he was a member and most of the time President of the Town Council of Cambridge, which he has done much to adorn. In April, 1882, he was elected one of the vice-presidents of the Medical and Chirurgical Faculty of Maryland.

Such is a brief and imperfect record of the laborious and well-spent life of this medical veteran, who has so ably maintained a fifty years campaign in the cause of humanity against disease and quackery, and who now retires from the field with the well-earned "accompaniments" of a virtuous and "kindly" old age—"love, honor, obedience and troops of friends."

"*Serus in coelum redeat dinque laeto intersit populo!*"

Yours truly,

JNO. R. QUINAN.

1362 N. Gilmor St.

Then and Now.

The Medical and Surgical practitioners of the present day do not, and cannot appreciate the very many and wonderful discoveries and improvements which have been made in the last fifty years, as we "old doctors" do, who knew them not, and had to struggle along as best we could with the lights before us, through many trying difficulties and troubles, that not unfrequently beset us. There is chloroform and its kindred anæsthetics, the choicest blessing to suffering humanity and the greatest help, a tenth legion to the surgeon in the successful performance of delicate and intricate operations, without which, I very much doubt if they could be done at all. With anæsthetics the operator of to-day, with his enlarged pathological and scientific knowledge and his improved and ingenious instruments, performs operations, and successfully too, in cases, which in old times were considered beyond all human skill, and where if perchance one should have been so bold and daring as even to suggest the surgeon's knife, his sanity would have been questioned. To illustrate.—In the spring of 1833 my preceptor, Dr. Samuel Baker, and his office students were invited to the late lamented, Prof. N. R. Smith by see him perform the operation of lithotomy, with his then newly invented instrument (gorget), made famous in his hands.

The patient was an old gentleman, the Rev. Mr. Healy, a Baptist preacher, residing in Old Town. Being placed on his back on a table, his legs properly elevated and flexed, the feet securely fastened in shoes attached to two upright standards firmly fixed to the table, his body and arms firmly held by assistants, the operation was begun and ended amidst distressing cries and groans and most piteous exclamations, making one's heart ache as they grated upon his ear. The operation was perfectly successful. Not long ago, during a visit to your city, my very highly prized friend, Dr. Alan P. Smith, invited me to be present to witness him perform the operation of lithotrity, the patient being the Rev. Dr. Guard, of Mount Vernon Church. An anæsthetic being administered, he was very soon rendered perfectly unconscious, and the operation accomplished in the most beautiful and skillful manner, and not amidst ejaculations of agonizing suffering and muscular contortions, but still and passive at the time as if in actual death. What a change from "Then to Now?" It is rather a singular coincidence that I should for the first time see the operation of lithotomy performed by the father and after fifty years, that of lithotrity by the son, and both too upon Ministers of the Gospel.

City vs. Country Practice.

A city physician has but a faint idea of the life of a country doctor; his exposure and suffering in long, cold, dark and stormy rides, and at times, his mind distressed with most anxious thoughts of some critical case, and no professional brother to consult with, or render assistance. At times too, when far off in the country, he is unexpectedly called to a case for which he is unprepared with remedies, and has to rack his brain for *succedanea* to meet the emergency. It may be a case demanding the use of instruments, and not having any with him, his ingenuity is taxed to the uttermost to improvise some kind of a thing to meet the requirements of the case. To illustrate.—At one time on my returning home from visiting a patient many miles in the country, I was urged to go and see a patient in the neighborhood and on reaching the house, I was shocked at finding a woman completely worn-out and exhausted from protracted labor of two or three days. On examination, I found the head of the child was about half through the upper strait and was there stuck from profound inertia of the uterus and general exhaustion of the vital powers, which ergot and strong stimulants failed to overcome. Her situation was indeed most critical, and demanding something to be done to effect the delivery of the child, as the resources of nature seemed exhausted and death staring her in the face. I had no obstetrical instruments with me, but it

happened in looking around with most anxious and bewildered thoughts, my eyes fell upon a dilapidated stove, and one of the rods, which had once held it together, sticking out, and instantly the idea flashed across my mind that I could utilize it, and at once set to work and fashioned it into a sort of *crotchet*, and with it very soon took the child away without the slightest injury to the soft parts of the mother.

At another time, whilst on the road to see a patient, I was stopped by a servant in rapid speed on his way to town after me, to come as quickly as possible to see master, who had accidentally been cut with a scythe blade and was bleeding to death. On reaching the gentleman I found him very weak and feeble from loss of blood and the wound still bleeding very freely from several small arteries. Not having my pocket case of instruments (which I generally carried) the necessity for prompt action suggested a fish-hook, which being obtained, the head was filled off, and with it, I soon took up the bleeding vessels and made my patient comfortable. The above cases are mentioned merely and solely for the purpose of showing the tight places in which we country doctors are caught. But for my opportune arrival and presence of mind, he would have bled to death before assistance could have been procured from town.

The Lincensing Powers of the Medical and Chirurgical Faculty Repealed and its Results.

Soon after my graduation, (viz: May 30, 1835,) I became a member of the Medical and Chirurgical Faculty of Maryland for at that time no one could legal ly practice medicine in the state without being either a member of it (the Faculty) or having a lincense from one of the Boards of Examiners for the Eastern or Western Shore. *A diploma was but a certificate of professional qualification, but did not carry with it the legal right to force the collection of fees for services rendered.*

That law was after many years repealed by political demagogues to carry favor with the "dear people," who were infatuated with a most arrant system of Quackery then very popular, Ycleped The "Thompsonian Botanic System," based upon the doctrine, that heat was life —cold, death, and their remedies were powerful, stimulating and irritating agents, in conjunction with steam baths, hence they were sometimes called "steam doctors."

One of their remedies was "No. 6," composed of the most heating and irritating articles, red pepper was in especial relied on and indiscriminately used in almost all cases, either by the mouth or by the rectum.

Now as they could not, as the law stood, compel those that had survived their ordeal to pay for services rendered, the dear people their friends, became clamorous for the repeal of the prohibitory law, and in an evil hour and to its everlasting shame (and the writer might have added, the destruction of the community) the legislature swept it off from the statute book. In illustration of the disastrous results I cite the following cases:

I was called many years ago, when Thompsonianism was in full blast to see a gentleman who had been suffering from an attack of acute dysentery, and by the persuasion of a neighbor, had sent for one of these selfstyled "doctors." I found him extremely ill, in fact passed all doing for, and died in a day or two from intense inflammation and sloughing of the rectum and contiguous parts. Now what do you suppose the miserable pretender had done? Why, *frequent injections of that 'Panacea,' thin fiery No. 6, into the rectum!*

Another case was that of a beautiful, interesting young lady, whose husband had been induced to discard his old, well-tried family physician and to have with his wife in her first confinement, one of the "new lights."

Shortly after her delivery, why or for what purpose, God only knows, he had injections of 'No. 6' thrown into the rectum, and as a necessary consequence, the most agonizing pain and distress, with intense inflammation of the rectum, bowel and bladder were excited.

The 'miserable creature' got scared and abandoned her to her fate. The old family physician was called in, and finding her in such distressing and dangerous condition, requested a consultation with me, and said,most sad was it to behold one so young and beautiful lying in such a hopeless condition, a victim of vile, impudent quackery. She died in a few hours.

Such were the imposters and murderers that the State of Maryland fostered and legislated equals of her highly educated, medical graduates!

The above cases are fair samples of the results of Thompsonianism, and the repeal of the License Law, and such will always be the result, till a similar License Law is restored.

A Case of Compound Communicated Fracture, Excision, Cure under Adverse Circumstances.

In April, 1839, it was nearly night, and I had just returned home, very tired from a long ride of 25 miles to visit in consultation, a case of lumbar abscess, in the adjoing County of Caroline, when I was most urgently requested to go to a poor old man living in the woods near the village of Tobacco Stick, 14 miles away. The account given me of the case made so strong an appeal to my feelings, that I could not refuse and started with all things necessary for amputation. A rain and thunder storm was threatening, and with most uncomfortable feelings, I got in my carriage and when within four or five miles of my destination, the storm in all its fury burst upon me, and the darkness made more dark by the vivid lightning and torrent rain,was such that I became unable to guide my horse,and had to call on the accompanying messenger to lead him; and without his assistance and familiarity with the road, I should not have found my way to the house, a small dilapidated cabin in the woods; and then I found my patient, who had in the early morning been thrown from a timber cart,and a compound comminuted fracture of the tibia and fibula the consequence. On examination, I found the tibia fracture just above the maleolus and protruding through an ugly wound to a level with the inner side of the sole of his foot, the end somewhat shivered and the fibula broken in several pieces. He was suffering a gooddeal. Now what to do, was the question? Amputation seemed to be demanded, but there was no one to assist but two or three scared, ignorant neighbors, no light but a blaze of a fat pine knot, and, under the circumstances, I declined to operate. He was an old man, 68 years of age, yet of a strong, vigorous constitution and did not appear to be much exhausted,so I determined to patch him for the night, and next morning to get the assistance of a medical friend and then amputate the limb.

The end of the tibia had been so long extended, that it was impossible to get it back in its entirety to the lower end of the bone, from the spasmodic resistance of the muscles. *I then had never heard, nor seen the operation of excision*, but as there was no other course left me but to saw off the end of the tibia,so as to get the two ends in juxtaposition, I determined to do so. After picking out the broken fragments of the fibula, I made one of the least timid present draw down the foot as far as possible and hold it firmly, and protecting the soft parts as best I could, I sawed off about two inches of the bone, all that was splintered and then without difficulty adjusted it to the lower end, and placing the limb semiflexed on a pillow, I dressed the wound and gave a dose of laudanum, with directions to repeat it, if necessary, and left to pass the night at a neighbor's house. Visiting him next morning, I was most agreeably surprised to find him so comfortable and cheerful and doing so well that I determined to let him alone and bide events. In the course of some months, after much professional anxiety and trouble, he was up and about, the wound perfectly, healed and the tibia so firmly united that he could walk on it with entire confidence, the only inconvenience being its want of proper length. He lived many years afterwards, without having any trouble with the injured parts.

His recovery was indeed remarkable,

and hardly to have been expected from his advanced age, the surroundings of poverty, etc., and the happening of accidents most unique; once a hungry mouse made a raid on the dressings of his leg and so started him from sleep, as to displace the uniting ends of the bones. At another time, a snake from the surrounding woods sought her shelter by his leg and, like the mouse, again disarranged the fragments and healing process; yet despite of so many adverse circumstances, he made a good recovery.

The Horse-shoe Magnet Employed Successfully, Surgically and Medically.

Sometime in the summer of 1846, John, a slave hired as a striker to a blacksmith doing work for the carriage factory of Carey & Schleigh, whilst assisting in welding a piece of red hot iron, a fragment flew off and embedded itself in the laminæ of the cornea. The pain at the time, was excruciating and thinking it was only some ordinary foreign substance, he began rubbing the eye to free it, but this so aggravated his suffering, that he ceased to make any futher efforts for its removal, and came hastily to my office for relief. Fortunately I was in my office when he came rubbing his eye and crying from the acute pain. Upon being seated, I began to examine his eye, which was so extremely sensitive to light that he could not bear to open it but for a moment, or so, yet with the assistance of my student, (Dr. Thos. H. Williams, late Surg. U. S. A., and C. S. A.) I succeeded in satisfying my mind of the condition of things. The conjunctiva was fiery red and very much injected, and I could distinctly see the *point* of a piece of metal sticking out from the *cornea*, just beyond the centre. Now what to do, I did not know, and for the moment was completely at my wits-end. No anæthetics (nor cocaine) in those days existed, or was dreamed of to bless suffering humanity and so greatly aid the surgeon. Laudanum and whiskey were then sometimes used, but I never saw any good they did, and so I had nothing to rely upon at my command to deaden the pain and make still the excessive mobility of the eye-ball and the constant irregular contractions of the muscles and twitching of the lids. Now to operate with instruments under such embarrassing circumstances, seemed to me impossible without running a greater risk of inflicting more lesion to the cornea than intended and it might be seriously impairing, if not destroying its usefulness.

Suddenly turning to my student I exclaimed, Tom, I wish you would go quickly and ask Dr. M.—— to loan me his large *Horse-shoe Magnet*, and very soon he returned with it, and now steadying the eye and keeping the lids apart, as well as he could, I approached the poles of the magnet gradually to the eye, and when within about a half or quarter inch of the cornea, I held it steadily in that position for a moment or so, when the patient suddenly cried out, Oh Doctor! I feel it coming out and it does hurt so,and sure enough,there it was on the surface of the cornea and was soon passed out by muscular action and tears. He was now comfortable and happy,and I my student, Tom, were not a little pleased and proud at the success of *the, then to us, unheard of* operation. The piece of iron was about the size of a No. 8 bird-shot irregularly flattened and triangular in shape. I directed him to go home and keep his eye well protected from the air and light, and bath it frequently in warm water and milk. In the course of a few days, he came to see me and entered my office not with tears and distorted visage, but all radiant with smiles. Examining the eye, I found all right with only a slight arborescent injection of vessels of the conjunctiva, and could scarcely perceive the place of exit of the piece of metal. He was free from all pain and in the course of a week or so, his eye was as well and his vision as good as if nothing had ever happened.

Note by Dr. Quinan.

To the above remarkable and original use of the Magnet, Dr. Bayly adds the details of two other cases of hysteria, or hystero-catalepsy, one in a girl, the

other in a feeble, nervous man, both of which were brought out of their fits and restored speedily to consciousness by the application of the Magnet, held firmly astride of the cervical vertebræ, no other agent being employed. The man frequently had it subsequently applied and always successfully. Query, were these results *post* or *propter hoc?* moral, or physical? Be the explanation that it may *finis coronat opus*, the cases were relieved, and that justifies the means whether we can satisfactorily explain the *modus operandi* or not. If my present information be correct, Dr. Alex H. Bayly is not only to be credited with his own originality in the surgical use of the Electro-Magnet, in removing metalic bodies from the eye, but with being the first man in Maryland, at least, to so employ this agent and I believe the same remarks is true as to excision.

DRAFT OF A LAW TO REGULATE THE PRACTICE OF MEDICINE IN THE STATE OF MARYLAND.

SECTION I.—Be it enacted by the General Assembly of Maryland, That every person practicing medicine, in any of its departments, except Dentistry, shall possess the qualifications required by this act. If a graduate of medicine of a legally chartered medical institution in good standing, he or she shall present his or her diploma to the State Board of Medical Examiners herein named for verification as to its genuineness and the good standing of the institution from which it is issued. If the diploma is found genuine and institution of good standing, and if the person named therein be the person claiming and presenting the same, the said Board of Medical Examiners shall issue its certificate to that effect, signed by all the members thereof, and such diploma and certificate shall be conclusive as to the right of the lawful holder of the same to practice medicine in this State. If not a graduate, the person practicing medicine in this State shall present himself or herself before said Board and submit himself or herself to such an examination as the said Board may require; and if the examination be satisfactory to the examiners, the said Board shall issue its certificate in accordance with the facts, and the lawful holder of such certificate shall be entitled to all the rights and privileges herein mentioned.

SECTION 2.—And be it enacted that The Medical and Chirurgical Faculty of Maryland, shall annually appoint five of its members, and the Homœopathic Medical Society, of the State of Maryland, shall annually appoint two of its members, who, together with the five members of the Medical and Chirurgical Faculty of Maryland, hereinbefore mentioned, shall constitute a State Board of Medical Examiners, who shall hold their offices for one year, and until their successors shall be chosen. The examiners so appointed shall go before a county judge, and make oath that they are regular graduates or licentiates of a Medical College in good standing, and that they will faithfully perform the duties of their office. Vacancies occurring in the Board of Medical Examiners, shall be filled by the Society which made the original appointment.

SECTION 3.—And be it enacted that The State Board of Medical Examiners shall organize within three months after the passage of this act, by the election of a president and secretary from among their own number, they shall procure a seal, and shall receive through their secretary applications for certificates and examinations; the president of the Board shall have authority to administer oaths, and the Board take testimony in all matters relating to its duties; they shall issue certificates to all who furnish satisfactory proof of having received diplomas, or licenses from legally chartered medical institutions in good standing; they shall prepare two forms of certificate, one for persons in possession of diplomas or licenses, the other for candidates examined by the Board; they shall furnish to the County Clerks of the several counties and to the Health Commissioner of the City of Baltimore, a list of all persons receiving certificates; they shall hold at least four meetings in each year, and in selecting places to hold their meetings, they shall, as far as is reasonable, accommodate applicants residing in different parts of the State, and due notice shall be published of all their meetings. Certificates shall be signed by all the members of the Board granting them.

SECTION 4.—And be it enacted that said State Board of Medical Examiners shall examine diplomas as to their genuineness. The verification of the diploma shall consist in the affidavit of the holder and applicant; that he or she is the lawful possessor of the same, and that he or she is the person therein named. Such affidavit may be taken before any person authorized to administer oaths and the same shall be attested under the hand and official seal of such officer, if he have a seal. Graduates may present their diplomas and affidavits as provided in this act, by letter or by proxy, and the State Board of Medical Examiners shall issue its certificate the same as though the owner of the diploma was present.

SECTION 5.—And be it enacted that all examinations of persons not graduates or licentiates, shall be made directly by the Board, and the certificates given by the Board shall authorize the possessor to practice medicine and surgery in the State of Maryland.

SECTION 6.—And be it enacted that every person holding a certificate from the State Board of Medical Examiners shall have it recorded in the office of the Clerk of the County in which he or she resides, and the record shall be endorsed thereon. Persons holding certificates residing in the city of Baltimore must have them registered in the health office of said city. Any person removing to another County to practice shall procure an endorsement to that effect on the certificate from the County Clerk, and shall record the certificate in like manner in the county to which he or she removes, and the holder of the certificate shall pay to the County Clerk the usual fee for making the record.

SECTION 7.—The County Clerk and the Health Commissioner of the City of Baltimore, shall keep, in a book provided for the purpose, a complete list of the certificates recorded by them, with the dates of issue of said certificates. If the certificate be based on a diploma or license, they shall record the name of the medical institution conferring it, and the date when conferred. The registers of the County Clerk and the Health Commissioner of Baltimore, shall be open to public inspection during business hours.

SECTION 8.—And be it enacted that candidates for examination not holding diploma shall pay to the secretary of the Board a fee of ten dollars, those holding diplomas a fee of one dollar which shall be returned to them if a certificate be refused. The fees received by the Board shall be paid into the treasury of the State on the first of April and the first of October of each year.

SECTION 9.—And be it enacted that examinations may be made in whole or in part, in writing, and shall be of an elementary and practical character, but sufficiently strict to test the qualifications of the candidate as a practitioner of medicine and surgery.

SECTION 10.—And be it enacted that any person shall be regarded as practicing medicine within the meaning of this act, who shall profess publicly to be a physician or to prescribe for the sick, or who shall append to his or her name the letters "M. D." But nothing in this act shall be construed to prohibit students from prescribing under the supervision of preceptors, or to prohibit gratuitous services in cases of emergency. And this act shall not apply to medical officers of the United States Army, Navy, or the Marine Hospital Service, who may be on duty in this State. Provided. —That nothing in this act shall apply to physicians coming temporarily from other States of the Union for purpose of consultation with legally qualified practitioners of this State.

SECTION 11.—And be it enacted that any person practicing medicine or surgery in this State without complying with the provisions of this act, shall be punished by a fine of not less than fifty dollars, or by imprisonment in the County jail or the Baltimore City jail for a period of not less than thirty days, nor more than three hundred and sixty-five days, or by both such fine and imprisonment for each and every offense, and any person filing, or attempting to file as his or her own, the diploma or certificates of another or a forged affidavit of identification, shall be guilty of a felony, and upon conviction shall be subject to such fine and imprisonment as are made and provided by the statutes of this State for the crime of forgery, but the penalties shall not be enforced till on and after the thirty-first day of December, Eighteen hundred and Eighty-six.

Provided.—That the provisions of this act shall not apply to those that have been practicing medicine five years within this State.

SECTION 12.—And be it enacted that this act shall take effect from the date of its passage.

Correspondence.

HYOSCINE HYDROBROMATE—CLINICAL REPORT; EDUCATION AND INSANITY.

MARYLAND HOSPITAL FOR THE INSANE,
February 9th, 1886.

Editor Maryland Medical Journal.

DEAR SIR:—Desirous of spending a year in the country, with opportunities for general and clinical study, it was my good fortune, some three months ago, to enter on the care of the female patients (182) in the above institution.

Before fulfilling my promise of reporting on our recent experience with Hyoscine Hydrobromate I may be allowed to utter certain thoughts which this new field of labor has strongly presented to my mind.

While the general practitioner does not often concern himself with the treatment of pronounced insanity, mental derangements, varying in degree and intensity, are the constant associate and sequence of many ordinary bodily disorders—notably, of those of the abdominal and genito-urinary organs. A knowledge of this inter-relation and a command of mental therapeutics are not, then, to be lightly disregarded. In recognizing the dependence of insanity upon change in nervous structures, the trend of modern thought would by no means restrict its causation to changes in the brain alone. Dr. Savage suggests as an ætiological mode "irritation propagated along nervous tracks at a distance from the nerve centres."

The increase of insanity among our population is more and more noticeable, each year. Has high-pressure education much to do with it? "True education, that is, the true development of mind and body, is the best preventive of insanity—over education or bad education consists really in the development of one side of the human being at the expense or to the neglect of the rest; educating a child along the lines to which its tastes lead it, without paying sufficient attention to correlated func-

tions." (Savage) Unquestionably, the best equipped counselor of the State, on this important subject, ought to be the medical alienist of broad and liberal culture. Where is the educated doctor in politics? When the demand comes for his services (the want has long existed) who will answer it? The graduates of our Medical Colleges—who have for the most part, found no preliminary requirements as to mental training barring their progress towards a Doctor's degree. May not Dr. McIntire, of the American Academy of Medicine, well ask "if classing the *medical business* among the learned *professions* is not altogether a mistake—when statistics show that the percentage of medical students possessing degrees in the arts or sciences in the schools reporting* such degrees in 1880 was 16.7—while law showed 32.0 per-ct. and theology 52.6 per-ct." (The last meeting in our city of this scholarly association whose mission is defined as follows: "to convince the public that a preliminary training of the mind is absolutely necessary for the greatest efficiency of medical men" hardly called out a respectable showing of those interested in its discussions). Let there be less "lop-sided mental development" as Dr. Martin† has phrased it, admitted to our ranks; and rather let us hear officially inculcated the need of a thorough *symmetrical* training of all the faculties of mind and body and soul, with appropriate time allotted in which to accomplish it. Of many general misconceptions about the insane, I note simply the following: that unusual capacity of some kind is not rare among the asylum inmates. Genius and insanity may go arm-in-arm, but the genius will contrive to keep the insanity on the safe side of the borderland; i. e., on the outside of asylum qualifications. This type of genius will often prove to be an abnormal development of some individual faculty, with a consequent dwarfage of the rest due to its excessive draught on the quantum of nervous power possessed by the person. Unity of purpose and concentration of effort will often account for the achievements of the ingenious element among the insane. Thus, as a scholar may contemplate one of the Greek articles until he offers the world a book about it, or, a medical graduate pivot his mind on some particular organ and discover an epidemic in which it is concerned, so one who limits his aspirations to the attainment of personal liberty, for example, may elude the closest scrutiny and "vanish like the schismatic taints of the rainbow;" in each case we admire the devotion of a "specialist."

Hyoscine Hydrobromate, of Merck's manufacture, was introduced to the hospital some six weeks ago and since then it has been in daily employ, approving the suggestion of Dr. Wetherill, jr., (*Medical Times*, Dec. 26, 1885) a solution was made with aq. destill. and alcohol, 10 per cent. of the latter as a preservative. Dr. Gundry called our attention to the rather surprising statement in the above paper, that this mydriatic produced "free diaphoresis as a physiological effect" (p. 239). Reference to Dr. Judson B. Andreus' report (*American Journal Insanity*, October, 1885,) which also quotes a summary of Dr. H. C. Wood's physiological experiments with the same drug, reveals no mention of any sweating action. Having administered hyoscine in doses of $\frac{1}{150}$ gr. to $\frac{1}{75}$ over a hundred times, I have never observed this effect, personally, nor have had it reported to me by those in constant attendance on the patients. The experience on the male side is the same. As regards slowing of pulse and respiration, increase of temperature, dryness of throat, dilatation of pupil, muscular relaxation and impaired co-ordination, my notes tally in the main with those of Dr. Wetherill.

The cases thus treated included acute and chronic mania, mania with hystero-epilepsy, chorea with insanity and melancholia. As a hypnotic, doses of gr. $\frac{1}{150}$ to $\frac{1}{75}$, given at night, have acted well—perhaps better than the bromidia combination. Hyoscine hydrobromate has the great additional merit of tastelessness and smallness of dose. In ordinary

*67 in number.
†Human Body.

insomnia, it will, I think, behave very satisfactory, in gr. $\frac{1}{120}$ doses.

As a cerebral spinal sedative it has proved of decided value, quieting the insane in their talkative noisy and demonstrative phases. Sometimes gr $\frac{1}{120}$ t. i. d. is desirable, and again, larger, single doses are more effective. Of course its action is uneven on different subjects now and then. There is no enlargement of the pupil noticed or dryness of the throat complained of. The excitement may occasionally seem to be increased, when the dose is rather large. The unpleasant effects, such as nausea, headache, loss of appetite, etc. have occurred to our experience. One case taking gr. $\frac{1}{120}$ regularly, ter in die, developed a profuse diarrhœa—not assignable to any other cause. The choreic patient, a female adult affected for over a year, has not improved much, so far, under a week's treatment. Dr. DaCosta reports a very severe case of the kind, yielding success to hyoscyamine, (*Philadelphia Medical Times*, January 23, 1886).

In the present paper it is not my object to enter on special details, but to encourage a more extended trial of this potent drug. I have not seen it stated that any one has administered a larger dose than gr. $\frac{1}{33}$, with safety On two occasions, where patients had been taking night doses of Mercks' amorphous hyoscyamine, gr. $\frac{1}{4}$, or even 3 j. of fluid extract hyoscyamus, as much as gr. $\frac{1}{16}$ of hyoscine was given without any serious or even marked depression of the circulation. This would indicate that the kindred preparations may establish a tolerance for this new principle.

One of our colored men has a variable pulse ranging, apparently ad libitum, between the limits of 44 and 80. The 40-end was *first* counted *during* an attack of uræmic coma, oddly enough; and points a moral.

In conclusion it may be said that every new drug succeeds at first, and while . very favorably impressed with hyoscine, I would not be understood to ignore the influence in results especially with nervous diseases, of change of environment, increased attention, and hopeful expectancy of both patient and doctor.

Very Respectfully,
E. M. Schaeffer, of Balto.
Asst. Physician, Maryland Hospital for the Insane.

Society Reports.

PHILADELPHIA CLINICAL SOCIETY.

STATED MEETING HELD JANUARY 22, 1886,

The President, Dr. E. E. Montgomery, in the chair.

THE FOLLOWING OFFICERS WERE ELECTED FOR THE ENSUING YEAR:

President, Dr. John B. Roberts; 1st. vice president, Dr. Clara Marshall; 2d. vice-president, Dr. Daniel Longaker; treasurer, Dr. L. Brewer Hall; recording secretary, Dr. I. G. Heilman; corresding secretary, Dr. Rebecca S. Hunt; reporting secretary, Dr. Mary Willits; councillors: Drs. Henry Beates, Tooth, Henry Hartshorne, Hanna T. Croasdale and Susan P. Stackhouse.

Dr. *John B. Roberts* mentioned a case in which there was a

TRANSUDATION OF FLUID ON THE CHEEK, IN THE REGION OF THE PAROTID GLANDS, DURING MASTICATION.

On examination of the buccal opening of Steno's duct a muco-purulent fluid was pressed out. A probe was introduced into the duct, for an inch or more and the canal stretched; on the return of the patient a day later, he reported that the transudation was less than it had been. The duct was again dilated with the probe. No calculus was found either time the probe was used. The patient had suffered from an abscess in this region three or four years ago, but the cicatrix did not seem to be located over the line of Steno's duct. On the introduction of the probe into the duct, an inch or more, the end could be distinctly felt through the skin of the cheek,

but it may not have been abnormally perceptible. Dr. Roberts said that he did not understand the pathology of the case, but believed the fluid to be saliva. He had intended to collect some for chemical testing, or blotting paper, but the patient returned to the country. Perhaps the occlusion of Steno's duct, was due to imflammatory changes, a catarrh in fact, and the occlusion damned up the saliva, which in some way by effect of pressure found its way into sudoriferous and sebaceous glands or ducts, and thus reached the surface.

Dr. Henry Hartshorne said that he had seen a case of this nature while he was a student of medicine. The exudation was in the region of Steno's duct, and there was moisture enough to necessitate its removal by the handkerchief. He could not remember whether it occurred only *during* mastication or not.

Dr. Clara Marshall said that in reading the article on belladonna in Ringer's "Hand-book of Therapeutics," she noticed the follow statement: "In the curious case of a middle aged man who suffered from excessive sweating of both cheeks while eating, the sweating ceasing immediately after the meal, ten drops of tinct. belledonna thrice daily checked the sweating completely." It is barely possible that in *this* case secretion was a transudation of saliva.

MARY WILLITS, M.D.,

Reporting Sec.

A REMEDY FOR PAINFUL DENTITION.—The "Union médicale" for January 9th gives the formula of a syrup containing the following ingredients, which it attributes to M. Bouchut:

Hydrochlorate of cocaine, Borate of sodium,	each,	1 part;
Syrup of marsh-mallow,		20 parts;
Syrup of white poppy,		10 "

The gums are to be gently rubbed with the syrup four times a day.—*New York Medical Journal.*

THE PREVENTION OF MYOPIA IN SCHOOL CHILDREN.—It is now tolerable well established that shortsightedness is developed and increased in a certain direct relation to the amount of school work done by children. For the prevention of myopia, Fuchs, of Liège, in a prize essay, quoted in the *Birmingham Medical Review*, gives the following directions. First in importance is the arrangement and lighting of the schoolroom.

"The principal windows in England should look to the south or south-east, The long axis of the room should run north and south. Every scholar should, from his place, be able to see some portion of the sky. Light from above is the best, and, except in hot climates, glass roofs are very advantageous. The chief light must come from the scholar's left side. The height of the top of the windows from the floor should not be less than two-thirds the width of the room. The total window-surface should bear to the area of the floor a proportion of at least 1 to 5. In artificial lighting by gas, every burner must have a glass chimney and a shade, the latter arranged to reflect the light down upon the desk, and to screen the scholar's eyes. There should be about one burner to every four scholars."

It is most important that the eyes should not be approximated too closely to the book. The proper position is that in which the shoulders and pelvis are parallel with the edge of the desk, and the head upright or bent but slightly forward. As to the construction of desks and seats, there must be several sizes, to suit scholars of various ages; the distance between seat and desk, in the vertical direction, must be but little greater than the distance between the elbow and the ischial tuberosity. The edge of the desk must overhang the seat about two inches; the scholar can then sit upright. The surface of the desk must slope about 1 to 5, to obviate the bending forward of the head; and the breadth should not be lees than 15½ to 16 inches. All stooping should be avoided, and the types used must be perfectly legible.—*Brit. Med. Jour.*, January 16, 1886.

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BALTIMORE, FEBRUARY 13, 1886.

Editorial.

THE YELLOW FEVER COMMISSION.—Considerable interest has recently been aroused in scientific circles in consequence of a bill which has been presented to Congress authorizing the creation of a special commission to visit Mexico and South America and investigate the work of Dr. Domingos Freire, of Brazil, and Dr. M. Carmona y. Valle, of Mexico, each of whom claim to have discovered a specific microorganism of yellow fever.

The bill referred to has been presented by Dr. Joseph Holt, the President of the State Board of Health of Louisiana, in behalf of the American Public Health Association. The bill recites the importance of an effort to secure an immunity from yellow fever, and asserts that there is a large and accumulating mass of testimony to the effect that "the power of protecting the unacclimated against yellow fever has been discovered and proven in the inoculation of the essential germ or cause of the disease, by methods distinctly formulated and available." Congress is asked to appoint a commission of three persons, one of whom shall be of known ability and special attainments in biological research, particularly in the department of microscopic investigation and culture of the essential germs causative of infectious and contagious diseases. The other two members of the commission, it is stipulated, shall be medical men of recognized ability, based upon long and ample experience, and competent to give expert consideration to all phases of the symptoms and course of yellow fever. The bill likewise provides that this commission shall proceed at once to Rio de Janeiro, as the first field of its labors, and, having completed its work there, shall also proceed to Mexico, and, if necessary, to Panama, Colon and Havana. Congress is asked to appropriate the sum of thirty thousand dollars, or so much of this sum as may be actually required to pay the expenses and salaries of the commission.

The manifest object of this commission is, no doubt, to investigate the work of Freire and Carmona, but the bill is so worded that a wider latitude of investigation is allowed should the commission find it necessary to extend its labors. For some months past the investions and discoveries of Freire and Carmona have been subjected to a good deal of criticism and their conclusions, which are very discordant, have been accepted with serious doubts. There is very little if any evidence of striking value to support the claims of either of these investigators, neither of whom show a thorough knowledge of microbiology. Whilst we are disposed to consider the discoveries of Freire and Carmona valueless, we must admit that much is to be learned by an investigation of the yellow fever germ in the tropics, if this investigation is conducted in a thorough manner and by bacteriologists of acknowledged skill. We can see no objection to an appropriation by Congress for the specific work of a commission, though we are of the opinion that the object aimed at by a commission could be reached in an equally satisfactory manner, and at far less expense, by a single expert in bacteriological work. The bill now before Congress provides for the appointment of a single bacteriologist who is supposed to be entrusted with the chief and only duties of the commission, that of microscopic investigation and culture of the germs. But the bill attaches as a body guard to the bacteriologist two medical men who are supposed to be able to give expert consid-

eration to the symptoms and course of yellow fever. We fail to see the advantage to be derived from the two medical attachés, unless we assume that these medical experts are charged with the special duty of investigating the symptoms and treatment of yellow fever as this disease is observed in the tropics. We have no desire to undervalue the importance of Governmental support to all scientific investigations. We think it eminently important that Congress should liberally provide for an investigation of the germ of yellow fever, or of any other germ which is capable of destroying human life, but when money is appropriated for a specific purpose there should be a reasonable assurance that the investigation is be conducted under the most advantageous scientific methods and not with a blow of trumpets and a stately exhibition of clap-trap. As a rule, a commission does far less work than a single individual; especially is this the case when the individual belongs to the Government service and is held responsible for the full performance of his duties.

Progress of Medical Legislation.—There is a vast difference in the legal status of the medical profession in the United States to-day as contrasted with that of ten years ago. In the majority of the States of the Union, State Boards of Health have been created by law and, in a number of instances, ample provision has been made for the support of these health organizations. The result has been that marked progress has been made in sanitation, and in the education of the profession and of the public in hygiene. In several of the States these Health Boards have been given a wider sphere of usefulness than that which has for its object the study of hygiene. We refer to the fact that these Boards have been charged with the duty of enforcing the law regulating the practice of medicine in their respective States.

To the States of Illinois, Michigan and West Virginia, special credit is due for the excellence of the laws regulating public hygiene and the practice of medicine. The good results which have been secured to the medical profession and to the general public in the States named through their respective Boards of Health and through the acts of the legislature regulating the practice of medicine, have led to a wider enactment of statutory laws. Up to the present time no less than twenty-nine States and Territories have passed laws to regulate the practice of medicine, whilst, we believe, in nearly every State and Territory a State Board of Health has been organized and in some way provided for by law. But few of the States have laws resembling each other in their special features. In some of the States the law regulating the practice of medicine is entrusted to a special Board of Medical Examiners which has no connection with the Board of Health. A difference also exists in the special features of the law in respect to the powers of the Board of Medical Examiners. In Virginia and North Carolina, we believe, a diploma does not give its possessor a legal standing. The Board makes its own standard and each applicant is forced to come up to a certain requirement. This law has the merit of exacting a high standard of graduation from the colleges of the country, but it has also a feature which may be used in a prejudicial manner against graduates from schools located in other States. The general tendency of the law is to force medical students into State institutions and not to place the holders of diplomas from outside institutions upon the same advantages. Very much, however, will depend upon the composition of the Board of Examiners whether all candidates for a license to practice are treated in a uniform and just way. It is quite important that a State Board of Examiners should consist of men who have no interest in the general results of the examinations beyond the requirement of a high standard of qualification of the candidates seeking its authority to practice. Hence, we think, the members of this Board should be physicians of the highest moral and professional attainments, and should have no connection directly or indirectly with any teaching body. Each

and every candidate should be subjected to a fair and impartial examination having for its general purport a test of the applicant's ability to practice his profession and not a mere test of his technical knowledge. Were such a strict requirement as this enjoined in every case the effect would be apparent upon the medical institutions of learning in the country. Those institutions which simply exist upon students' fees, without regard to the standard of graduation required, would soon feel the effect of the law and would be forced to close their doors or to make more solid provision for the education of students. If any one thing is overdone in this country it is probable the medical college business will come under this class. There are entirely too many medical schools and entirely too many medical students. A better quality of medical teaching is greatly needed and a smaller number of intelligent medical students is required. How to secure these two results is a problem which must sooner or later be solved. The profession in some sections of our country, at least, has been seeking a solution by special acts of legislation. The laws now in force in some of the States have done good work for the profession in demanding better instruction from medical colleges in their own territory, and have made it impossible for a man to practice without a diploma or without passing an examination.

The attempt to regulate the status of medical practice by legislation is one worthy of encouragement and fair trial. We see no other way of reaching the result greatly needed than by a law which entrusts the duties of passing upon the qualifications of a candidate to a competent Board of Examiners, and empowers this Board with authority to determine whether the Faculty of a teaching body shall or shall not be recognized as competent to pass upon the fitness of its graduates for medical practice. There are numerous details in the way of the successful organization of a Board of Examiners which we have not the time to consider. We believe, however, competent men can be found, in every State, in the ranks of the profession, to whom can be entrusted the successful execution of a law which has in view the general good of the profession and public. The important consideration is to secure the passage of a law so framed as to meet the requirements of the profession. This done the profession can rely upon its own authority to secure its just and impartial enforcement.

We are able to present to our readers, in another column, the text of a bill which has been presented to the Legislature of this State by a Committee of the Medical and Chirurgical Faculty of Maryland. This bill has been carefully drawn, and should it become a law its enforcement will be of marked value to the profession in the State. It is unnecessary for us to refer to the necessity for such a law as is herein provided for. We can only warmly advocate its passage and urge upon the committee to which it is entrusted, and upon the profession, the importance of pushing it through our present Legislature. The time seems opportune for the passage of a law to regulate the practice of medicine in the State. The present Governor and Legislature have shown themselves favorable to the passage of laws having in view the public health. We believe that the bill, to which we refer, will become a law in this State if an earnest effort and appeal is made during the present session of the Legislature. Those members of the profession interested in the passage of this law should bear in mind the fact that our Legislature holds only biennial meetings. A failure to secure the passage of this bill during the present session means its postponement two years hence, and, in all probability, its ultimate failure. The matter is of such importance that prompt and decisive action is demanded.

Dr. Aubert, of Paris, has lately published a short note on the advantages of the simultaneous administration of belladonna and the iodide of potassium. He claims for this combination the prevention of iodism, which occurs in some people even in small doses of the iodide.

Miscellany.

Annual Meeting of the Medical and Surgical Society of Baltimore.—The five hundred and thirty-fourth regular meeting of this society was held on the 28th of January. The following officers for the ensuing year were elected: President, Dr. Wm. H. Norris; Vice-Presidents, Drs. J. W. Chambers and M. B. Billingslea; Secretary, Dr. J. B. Schwatka; Treasurer and Corresponding Secretary, Dr. A. Trego Shertzer; Committee on Discussions, Drs. T. B. Evans, George H. Rohé and J. H. Branham; Executive Committee, Drs. Wilmer Brinton, A. V. Gosweiler and D. W. Cathell. After the usual business had been transacted, literary exercises having been dispensed with, the society adjourned to enjoy the annual banquet.

Dr. John Morris, the toast-master, called for thirteen regular toasts which were appropriately responded to. These embraced the incoming and retiring officers, the society, five medical colleges, the practitioner, the medical press, the women, the babies, and music.

Considerable merriment was produced by the humorous responses of Drs. T. B. Evans and A. Friedenwald.

A number of impromptu toasts were proposed, and after singing "Auld Lang Syne," the members wended their homeward way.

Conception After Curetting of the Uterus.—It has been made an objection to curetting of the uterus, that thereby, conception is rendered difficult, if not impossible (B. Schultze). Düvelius has reported sixty cases where, after curetting, conception did ensue, yet, in the discussion of his paper, no others were familiar with similar cases. Benicke has, therefore, carefully gone over his records, and is able to report ten cases where conception followed on curetting. Of these ten cases, the operation was undertaken once for the cure of endometritis hæmorrhagica, and in nine, for the removal of retained membrane. In three of the cases, the operation was repeated, so that altogether, it was performed thirteen times. In five of the cases, the conception ended prematurely, but this was not a result of aborting.

In two cases, conception ensued four or five weeks, respectively, after curretting; in the others, two and a half, three, four and a half, up to seventeen months after. Benicke's conclusion is that the fear lest curetting should interfere with further conception is absolutely groundless; indeed, that in many cases, it is an excellent method of preparing the endometrium for a new conception.—*Boston Medical and Surgical Journal*

Medical Items.

At the instance of the *Medical News*, Dr. Sternburg has subjected the newly discovered antiseptic Iodol to an investigation and finds that it has no germicidal power. He suggests, however, that as a powder in direct contact with a granulating surface iodol might have a certain antiseptic value, or possibly in the presence of a discharge from a suppurating wound it would be slowly decomposed, and iodine be set free, but this fact, he says, can only be determined by clinical experiment.

Dr. H. G. Piffard, the well-known and and able editor of the *Journal of Cutaneous and Venereal Diseases*, has retired from his editorial connection with this Journal, and resigned it entirely into the hands of Dr. P. A. Morrow, his former associate in this work.

The *Medical Record* states on the authority of Dr. Ireland that twenty-eight per cent. of imbeciles are left handed.

Mr. Lawson Tait has been elected president of the British Gynæcological Society.

The honor of knighthood has recently been conferred on Dr. Critchton Brown, a well-known London physician.

The *Evening Express* credits Mrs. Grundy with the saying: "That the doctor who writes a book, gives himself away, by showing that his time is not disturbed by patients."

Original Articles.

NOTES OF A SERIES OF CATARACT EXTRACTIONS BY VON GRAEFE'S METHOD.*

BY SAMUEL THEOBALD, M.D.

Surgeon to the Baltimore Eye, Ear and Throat Charity Hospital.

It is well known that at the present day the operation of cataract extraction by the modified linear method is variously performed by different surgeons, many slight changes in the operation as originally devised by Von Graefe having been introduced from time to time. These changes have been chiefly in the manner of making the corneal section; but, in the performance of the iridectomy, too, and in opening the lens capsule, different methods of procedure have been followed.

In the cases reported in this paper, the iridectomy, except in one instance, was made by a single cut with the scissors; the external incision was made throughout in the sclero-corneal juncture, the section being curvilinear rather than simply linear in shape, and the formation of a conjunctival flap being the exception rather than the rule; and the pupil was thoroughly dilated by atropia at the time of the operation. This method of making the iridectomy, which gives a comparatively small coloboma, is not the one usually followed, and it is chiefly on this account that I have thought this brief series of seventeen consecutive cases of cataract extraction of sufficient interest to be reported.

There have always been surgeons (among them Critchett and Lawson) who have advised the removal of but a small piece of iris in the performance of Graefe's operation; and it is generally admitted that the smaller pupil obtained in this way has optical, as well as cosmetic advantages, over the large, gaping coloboma which results from the excision of a considerable portion of the iris. In addition to these advantages, I have found, contrary to what is generally believed, that incarceration of the iris in the angles of the external incision is less apt to occur when a small iridectomy is made, by placing the scissors close to the edges of the incision, and, by a single cut in the direction of its long axis, removing, up to its ciliary attachment, only that portion of the iris which corresponds to the centre of the sclero-corneal wound, than when by several cuts the iris is excised from one to the other extremity of the wound. In the latter procedure the iris is dragged into the angles of the incision, where it is apt to become entangled, and from whence it is difficult to detach it by any sort of manipulation. On the other hand, it has not been my experience that iritis is of more frequent occurrence, or is more likely to lead to serious consequences, with a small iridectomy than with a large one.

Case I.—Sister M. L. N., colored, æt. about 68. Senile cataract in R. eye. The L. eye had been operated upon for cataract by another surgeon, several years previously, with poor success, severe iritis having occurred. For this reason it was deemed best, in order to diminish as far as possible the risk of similar trouble with the remaining eye, to make a preliminary operation of the iridectomy. Chloroform having been administered, the corneal section was made with a Graefe's knife, and the iridectomy completed without accident. Exactly one month afterwards, the eye being then free from hyperæmia, the lens was extracted through a linear incision, made throughout in the sclero-corneal juncture, the patient being under the influence of chloroform, and the pupil dilated by atropia. The writer's bandage was employed to close the eyes and to retain the dressings, which, as in all the cases reported in this paper, consisted of one thickness of linen next to the lids and a cushion of absorbed cotton, bird-nest-like in shape, carefully fitted over each eye. The wound healed kindly, and, after absorption of some cortical lens matter, of which there was at first a good deal in the pupillary area, $V=\frac{20}{XXX}$ was obtained. Subsequently, owing to wrinkling of the remnants of the capsule, the

*A paper read before the Clinical Society of Maryland, Feb. 5, 1886.

visual acuteness declined, and the capsule was twice needled, giving as a final result V=$\frac{20}{L}$ (?).

Case II.—Mrs. K. D., æt. 43. Hypermature cataract, with small nucleus, semi-fluid cortex, and tough capsule, in R. eye; immature cataract in L. eye. Operated upon R. eye, pupil under atropia. Some difficulty experienced in rupturing capsule, and a considerable quantity of the semi-fluid cortex was left in the eye. Atropia instilled the second day after operation. Cortical matter rapidly absorbed. Three weeks after extraction V=$\frac{20}{XXX}$. The record of this case does not state whether an anæsthetic was administered.

Case III.—George M., German, æt. 55, by trade a shoemaker. Hypermature senile cataract in L. eye; immature cataract in R. eye. Extraction done upon L. eye, without anæsthetic, pupil being dilated by previous application of atropia. Iridectomy made with one cut of scissors. Atropia (4 gr. solution) applied to eye on the third day after the operation. Healing progressed satisfactorily. Six weeks after operation V=$\frac{20}{LXX}$.

Case IV.—Mrs. H., German, æt. about 55, housewife. L. eye mature senile cataract, with small nucleus; R. eye immature cataract. Operation performed upon L. eye, under chloroform, pupil dilated by atropia. Iridectomy made as in previous case, and atropia applied on third day after operation. Convalescence rapid. One month after extraction V (with+ $\frac{1}{4\frac{1}{2}s}$)=$\frac{20}{CC}$, which ultimately was improved to V=$\frac{20}{XXX}$, through retraction of capsular opacity, and the correction of some traumatic astigmatism.

Case V.—James H., Irishman, æt 82, farmer. Dark, amber colored cataracts in both eyes (the so-called "black cataract"), immature in L. eye. Operated upon R. eye at Baltimore Eye, Ear and Throat Charity Hospital, atropia having been instilled beforehand. Recovery uninterrupted; left hospital at end of two weeks. Three weeks after operation V=$\frac{15}{LXX}$, ophthalmoscope showing evidences of former choroiditis.

Case VI.—Annie C., mulatto, æt. 40. Cataract in each eye, secondary to severe syphititic irido-choroiditis. Operated upon R. eye at Baltimore Eye, Ear and Throat Charity Hospital. The capsule was unusually tough, and the corneal section had to be enlarged to facilitate the escape of lens. Some bits of cortical matter were left, and underwent absoption slowly. A very clear pupil was, however, obtained ultimately, with V=$\frac{20}{CC}$, notwithstanding there were extensive pathological changes in the choroid and retina.

Case VII.—George M. This was the patient the operation upon whose L. eye is described in Case III. Shortly before the first operation the opacity in the R. lens, which had not impaired his sight enough to prevent his work at shoemaking, increased so rapidly within one week that he could not see to walk by himself. This sudden developement of the cataract was attended by slight pain in the eye, but there was no increase of T. The operation on the R. eye was performed at the Baltimore Eye, Ear and Throat Charity Hospital. No anæsthetic was employed; pupil under atropia. Extraction completed without accident. The case progressed favorably until the eighth or ninth day, when hypopion made its appearance, and a low grade of iritis developed, which was slow in disappearing, and left behind it a pupillary membrane. This was successfully needled, however, and V=$\frac{20}{L}$ was obtained.

Case VIII.—Mrs. E. M. C., æt. 72. This patient had been under observation for two years with a slowly progressing cataract in each eye. As her vision was very poor, and neither cataract was mature, a preliminary iridectomy was performed upon the L. eye, in which the cataract was more advanced, and the cortex of the lens "triturated" with the angle of a strabismus hook (as recommended by Förster), to hasten the ripening process. A slight iritis followed the operation, but soon subsided. Two months afterwards the cataract (which in the meantime had matured but little) was extracted without difficulty through a good-sized sclero-coneal section, the patient being under the influence of chloroform, which had been preceded by a

hypodermic of atropia and morphia. Convalescence rapid. Result, V=$\frac{20}{XXX}$.

Case IX.—Mrs. L., German, æt. 61. This patient had also been under observation for some months with a partially formed cataract in each eye. A preliminary iridectomy was performed upon the R. eye, and eight weeks afterwards the lens was extracted, both operations being done without an anæsthetic. Convalescence was slow after each, and some capsular opacity was left, which was subsequently needled. Ultimate result V=$\frac{20}{C}$.

Case X.—Mrs. Elizabeth H., German, æt. 54, sister to Mrs. H., Case IV. This patient had been under observation for a long time, sight being very poor from immature cataracts. In order to hasten the ripening process I performed an iridectomy upon the L. eye, and triturated the cortex of the lens with a a tortoise-shell cataract spoon. Within ten days a marked change in the lens was noticeable, and in less than three weeks it had become opaque throughout. The extraction of the cataract was not done, however, until three months after the preliminary operation, as the latter was followed by a somewhat persistent sub-conjunctival hyperæmia. The operation was performed at the Baltimore Eye, Ear and Throat Charity Hospital, under choloroform, preceded by morphia and atropia. The case progressed favorably, and the patient left the hospital on the 20th day. Result, V=$\frac{20}{L}$.

Case XI.—James H., colored, æt. 70. Mature senile cataract. Operated upon at the Baltimore Eye, Ear and Throat Charity Hospital, without anæsthetic. Left the hospital on the 25th day after the operation. V=$\frac{15}{XL}$.

Case XII.—Mr. F., Englishman, æt. 85, but in good general health. Mature cataract in L. eye; immature cataract in R. eye. Stillicidium and conjunctivitis from senile eversion of lower puncta. Having previously slit the lower canaliculus in each eye and prescibed a collyrium of boracic acid, and thus gotten rid of the stillicidium and conjunctivitis, the patient was given tonic doses of quinine for a few days, and the L. eye was then operated upon, without the administration of an anæsthetic. Atropia was instilled on the third day. The case did exceptionally well from the first, and the patient, who was operated upon at the Baltimore Eye, Ear and Throat Charity Hospital, went to his home on the sixteenth day. V=$\frac{15}{C}$ and some letters of $\frac{15}{L}$.

Case XIII.—Gilbert S., æt. 27. Soft cataract in each eye, mature in L., secondary to syphilitic irido-choroiditis. Although there was only central perception of light in the L. eye, the cataract was removed in the hope that some improvement in vision might result. The case did well so far as recovery from the operation (which was performed under chloroform) was concerned, though there remained some capsular opacity in the pupil. The vitreous humor was found to be opaque, however, and the deeper structures of the eye so damaged by the previously existing inflammation that nothing was gained by the operation. V=nil.

Case XIV.—Eliza A., colored, æt. 85. Mature cataract in R. eye; nearly mature cataract in L. eye. Patient was taken into the Baltimore Eye, Ear and Throat Charity Hospital, and the R. eye operated upon under the influence of cocaine. The case progressed favorable, and the patient left the hospital about one month after operation, with V=$\frac{15}{LX}$.

Case XV.—Charles C., colored, æt. 41. Myopia of high grade ($\frac{1}{5\text{X}}$) in R. eye; soft cataract, doubtless secondary to myopic changes, in L. eye. Hoping to give the patient useful distant vision in the L. eye, without the necessity of a strong convex glass being worn, the cataract was extracted, the eye being under the influence of cocaine. The whole lens was soft, and the operation was completed without accident, very little cortical matter being left, and the hyaloid membrane not being ruptured. The iridectomy, made by one cut of De Wecker's scissors, was of good shape and size, and there was no hemorrhage, either external or internal. The case did badly, however, from the first, the patient experiencing considerable pain in the eye the night after the operation; and, in spite of the liberal adminis-

tration of quinine and morphine, the eye was lost through suppurative panophthalmitis, and was subsequently enucleated. While under observation the patient had a severe attack of suppurative tonsillitis, from which he had suffered before, and, apart from the unsound condition of his eye (myopia), was a most unfavorable subject for operation.

Case XVI.—Miss Lucy McA., æt. 84. Mature cataract in both eyes, with nucleus in each large and very dark ("black cataract"). As is frequently the case in this variety of lens opacity, V was better than is usual with a mature cataract. L. eye counted fingers at 6″; R. eye, at 15″. Operated upon L. eye at St. Agnes Hospital, pupil being dilated by atropia, and eye under cocaine. Some little cortical matter left; iridectomy with one cut of scissors. Atropia, applied as usual, on third day after operation. Convalescence uninterrupted. V=$\frac{20}{LXX}$ (except one letter) and $\frac{20}{L}$ (?).

Case XVII.—John M. H., æt. 69. Incipient cataract in L. eye; immature cataract R. eye. Performed a preliminary iridectomy upon R. eye (under cocaine), and four months afterwards, the cataract having matured during the interval, removed the lens, again employing cocaine. Recovery rapid. V=$\frac{20}{LXX}$. Both operations performed at the Baltimore Eye, Ear and Throat Charity Hospital.

It is worthy of mention that in no one of the foregoing cases was there loss of vitreous humor during the operation, or other evidence of the hyaloid membrane being ruptured. In five of the cases the operation was performed with the patient under the influence of chloroform; in five, no anæsthetic was employed; in four, cocaine was used; and in three, the record does not state whether an anæsthetic was administered or not. In five cases the iridectomy was performed as a preliminary operation, and twice "trituration" of the lens was combined with the preliminary iridectomy. In four of these cases the cataract was immature, and the preliminary operation was done to hasten the ripening process; while in the other it was done to lessen the risk of inflammation, as a previous extraction operation upon the other eye had been followed by a severe irido-keratitis.

In considering the results obtained, we are justified in dividing the cases into two groups, since in several there were serious complicating conditions. In all of the uncomplicated cases (14) the operation was successful, the average acuity of vision obtained being high, V=$\frac{20}{XXX}$ in three cases, and in only one as low as $\frac{15}{C}$. Of the three complicated cases, in one, in which the cataract was secondary to extensive syphilitic irido-choroiditis, a clear pupil was obtained, but, owing to the condition of the retina, V was only $\frac{15}{CC}$; in another, the cataract was removed without difficulty, and the eye healed kindly, but the deeper structures of the globe had been so affected by previous disease, that no improvement in sight resulted; while, in the one remaining case, in which there was a high degree of myopia, destructive panophthalmitis supervened (though the operation had been completed without accident), and the eye was eventually enucleated.

It is worthy of remark that of the successful cases four of the patients were over eighty years of age—two being eight-five, one eighty-four, and one eighty-two. In all of these the healing process was rapid and uninterrupted, and the result, as regards acuity of vision excellent.

A CASE OF WIRING THE FRACTURED PATELLA*.

BY J. EDWIN MICHAEL, M. D.

Prof. of Anatomy and Clinical Surgery in the University of Maryland.

A. W., æt. 43, laborer, entered Bay View Hospital, October 31, 1885, suffering from an ununited fracture of the left patella. His account of himself is not satisfactory. It is about as follows: About a year ago he suffered from an attack of what the doctor called brain-fever during which he was delirious most of the time, and about which he knows nothing, except that upon recovery

*Read before the Clinical Society of Maryland, January 22, 1886.

he found his left leg almost useless on account of a broken knee cap. How it was broken or how treated, if treated at all, or even when treated, he is unable to say. Upon exposing the knee a transverse fracture of the patella was obvious. The fragments lay about three inches apart, separated from each other by a deep sulcus. Upon being requested to raise the leg from the bed in the extended position the separation between the fragments increased to about five and one-half inches and he was unable to raise the heel from the bed until flexion to very near a right angle had occurred. The patient could walk but in so doing used the leg as an artificial or paralyzed one, being able to bear his weight upon it only when in the position of full extension. The operation of opening into the joint and wiring together the fragments was proposed and explained to the patient and gladly accepted. On November 4th, the operation was performed in the following manner. The patient being etherized the extremity, from ankle to upper third of thigh was thoroughly scoured with soap and water. The same region was then freely washed with a solution of corrosive subtimate of a strength of 1 to 1,000. The hands of the operator and assistants, all sponges, towels, etc., which were to come near the wound were freely saturated and washed in the same solution. The instruments were kept when not in use in a solution of carbolic acid about 1 to 40. Carbolized cat-gut was used for ligature and suture. A transverse incision was made across the extremity about midway between the broken fragments of patella and the joint freely opened. The web of connective tissue uniting the fragments, was found to be very thin. The soft parts being now drawn upwards the upper fragment was exposed and a thin slice of bone removed with the saw. The lower fragment was next treated in the same way with the addition that an exostosis of small size was removed from its outer angle with the bone pliers. Holes were now drilled through the fragments beginning about three quarters of an inch from the upper margin of the freshened surface and ending at its lower margin in a slight excavation made for the purpose with the gouge as recommended by Lister. A silver wire something less than an eighth of an inch in thickness was now passed through the drill holes and the fragments drawn together. It was found that considerable traction was necessary in order to accomplish this. The lower margins, however, were caused to meet without the necessity of notching the tendon of the quadriceps. The upper margins could not, however, be brought together and there was hence a V. shaped notch between the two. I thought this interval would be filled with connective tissue if not with bone and moreover would be a very good place in which to conceal the ends of the wire and so disturbed myself no futher about it, the wire was now twisted and the ends bent down into the interval mentioned. The wound was now thoroughly cleansed and dusted with iodoform, a short rubber tube placed at either angle and the line of incision closed by means of the continuous catgut suture. Another dusting with iodoform, a pad of iodoform gauze, mackintosh and a bandage completed the dressing of the wound. The extremity being retained in the position of full extension was now incased in a plaster splint and the patient put to bed. On the day after the operation the patient complained of pain at the seat of the wound and received a small dose of morph. sulph. which relieved it. On the third day the temperature reached a fraction over 99° which was the highest during the progress of the case. From this time the history is monotonous, no fever, no pain, no discharge. On November 25th, three weeks after the operation, the dressing was changed for the first time. The line of incision was found to be solidly healed up except at the points where the drainage tubes kept it open. No movements were attempted, the wound was dressed and the splint reapplied. December 10th, all healed, union between fragments firm, but not osseous. Passive motion attempted and flexion carried to about half its full ex-

tent. Shampooing with liniment and frequent passive motion directed. Patient can raise the leg from his bed in the extended position. Is now allowed to walk on crutches, but still wears a splint. January 15th, patient walks without cane and with no other support than a bandage. Can flex the leg to considerable extent and has full power of extension. He is now employed as one of the waiters in the institution.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JAN. 22, 1886.

After regular order of business, the following papers were read:

Dr. J. Edwin Michael reported

A CASE OF WIRING THE FRACTURED PATELLA.*

DISCUSSION.

Dr. O. J. Coskery thought it would be of interest to show, in connection with Dr. Michael's case, one that had recovered under the old fashioned adhesive strap treatment. This case was the result of direct violence—a blow from a crank handle.

Dr. N. G. Keirle exhibited an anatomical specimen illustrating the condition of the joint in an old fractured patella. The union was entirely fibrous.

Dr. Randolph Winslow tendered his congratulations to Dr. Michael upon his brilliant success, obtained in the case just exhibited. In opening the discussion of the subject of wiring the patella for fracture, it is necessary to consider separately the method as applied to 1st, recent fractures, and 2nd, chronic cases, in which there is marked impairment of function; for whilst there is great unanimity of opinion in regard to the one, there is great diversity in regard to the other. Where an old fracture remains ununited, and the functions of the limb are seriously interfered with nearly all surgeons agree upon the propriety of attempting to obtain better results by cutting down upon the knee joint, and bringing the fragments together with wire, and the case of Dr. Michael is an excellent example of what may be done in such conditions; but in regard to recent fractures, many of the most eminent practical surgeons hold diametrically opposite views. Amongst those advocating primary suture of the patella will be found Sir Joseph Lister and Dr. McEwen, in Great Britain, and Dr. Dennis, of New York, whilst equally as good practical men, as Bryant, Holmes and Heath, condemn the operation in such cases. Let us consider 1st, whether better results are obtained by wiring than by splints, and 2nd, what are the dangers of the operation. In regard to the first proposition I will quote the opinion of Bryant, as found in the last edition of his text book, published in 1885. He says: "Within recent times surgeons have advocated the primary treatment by wiring, and successes have been obtained—some excellent, others indifferent, few better than the average obtained by the treatment above described. * * * I cannot recommend this practice to be universally adopted. It is eminently hazardous; and when we know that in the majority of cases of fracture of the patella treated without operation results are obtained, which in exceptional cases alone interfere with life's duties, the treatment by operation stands condemned as a rule of practice." He presents also a most interesting table of cases treated at Guy's in the ordinary way. Of 32 cases, 28 resulted in limbs "useful in every way," and in four there was more or less weakness of the limb, of the four in two the separation of the fragments was but ½ inch, in one 1 inch, and in the other 2 inches. Of those who recovered with useful limbs, a large number pursued laborious occupations, being carriers, sailors, porters, and engineers. One man could climb a ladder with two hundred weight on his shoulder. In one man who had a perfectly useful limb, there was a separation of the fragments to the

*See page 320.

extent of 3 inches. In another who could walk well both bones had been fractured, and there was a separation of 2 inches on each side. In another who had good use of the limb, there was 4 inches separation. In the majority there was ½ inch separation, and a satisfactory result.

A specimen presented by Dr. Winslow to this Society two years ago, showed a separation of 3 inches, and yet the limb from which it was taken did not show the least atrophy and had evidently been perfectly useful. Bony union does not necessarily signify good union, and it is indeed doubtful whether close fibrous union is not preferable. This is exemplified by those cases in which there has been a refracture after varying lengths of time, as the one reported by Stimson in which a refracture occurred after two months. In a number of the cases treated by wiring immediately, some excellent results have been obtained, but frequently complications or accidents of various kinds have occurred, as profuse suppuration, or necrosis of the upper fragment, or ancylosis or impairment of function, erysipelas and septicæmia. The ordinary treatment by splints whilst it may possibly not yield as good results in some cases, probably when an average is struck, will be found equally as satisfactory, and much less dangerous.

Let us see now what is the mortality inherent to the operation. Mr. John Wood, of London, reports four deaths in the first 50 cases operated on, and one additional from carbolic acid poisoning. Dr. Dennis says there have been no deaths in the second 50 cases, and yet one of his own died of erysipelas. Besides the direct mortality then, we have the other accidents and complications already mentioned. Dr. Dennis formulates three propositions in regard to the advantages to be derived from operation. 1st, the absence of danger to life and limb; 2nd, superior results as regards the function of the joint; 3rd, greater rapidity of repair.

It has been seen that in the first 50 cases four or five died, which shows there is considerable danger to life, even if more favorable results have been obtained since. From the fact that, suppuration, necrosis, and ancylosis have occurred in other cases, it is evident that the second proposition cannot be substantiated, and the discussion narrows down to the 3rd proposition, viz: that there is greater rapidity of repair after wiring, than when treated by splints. This is believed to be true, but are we justified in causing the death of one person in twelve in order to diminish the length of the treatment of the other eleven; or even if only one in 100 die, is it justifiable to operate, when almost the only advantage is the saving of a few weeks of treatment? Greater rapidity of repair goes for very little when compared with greater safety to the patient. Lister said he would advocate the operation, on account of his faith in the antiseptic system; even if all that was claimed, it did not hold good. In conclusion Dr. Winslow said: recent simple fractures of the patella do well enough without operation, hence he opposed opening the knee joint and wiring the fragments in such cases. On the contrary, in old fractures with wide separation of the fragments, and marked impairment of function, he thought the operation ought to be performed,

Dr. J. W. Chambers does not think the space between the fragments of the fractured patella ever sufficient to materially interfere with the quadriceps extensor muscle.

He thought that in those cases in which the function of the muscle had been impaired, that an effort should always be made to rescue it from its atonic condition by massage or electrical stimulation before any operative procedure was attempted on the joint.

It is his opinion that the fragments always become more or less separated after the limb has been liberated from the splint and the joint is brought into action.

Dr. R. B. Morison wished to direct the attention of those members of the Society who were interested in these matters and had not already seen it, to a report of 60 cases of the operation for fractured patella recently published in the *Vienna Medical Press.*

Dr. J. Edwin Michael don't wish to

be understood as being a disciple of any surgeon who recommends wiring together the fragments of a broken patella *as a rule*, but wishes to have it known that he judges his cases individually, and selects only those that he thinks favorable.

A difference should be made between fractures from direct violence and those from muscular contraction. He only advocates wiring in acute cases which present peculiar conditions; as where the fragments are wide apart or where the fracture is compound.

He has seen a case in which the limb was perfectly useful and yet there was an interval of three inches between the fragments of the fractured knee cap. This space was occupied by firm fibrous tissue. He thinks it immaterial whether the union is fibrous or bony.

Dr. G. M. Sternberg made some remarks upon the

MALARIAL GERM OF LAVERAN.

It was his intention to present a paper on the subject to the Society, but when he had completed it, it was found to be of such length that it would have taken up the whole of the evening to read it. He reviewed the work so far done on the subject.

He referred to the early publications of Crudelli and Klebs on the Bacillus Malariæ, which organism is now denied an existence. At that time Marchiafava claimed to have seen the same microbe. While in Rome, Dr. Sternberg, through the kindness of Dr. Marchiafava and Celli had seen the Malarial germ in the blood of patients sick of malarial fever. This body is identical with the "small round hyaline body" described in a paper on the Pathology of Malaria by Drs. Councilman and Abbott and read before this Society last winter.

The organism is possessed of ameboid movements; it is constantly changing in shape. At one stage it appears as a simple round disk, in another, arms appear; again motile flagella may be seen which by their lashing movements set into motion the surrounding blood corpuscles. Of course these bodies are only to be detected by the use of special apparatus. Through the kindness of Dr. Nordman, of Bay View Asylum, he has been enabled to examine the blood of malarial patients, during the paroxysm, but can not state positively that he detected the bodies. He has made similar examinations of malarial blood from other sources, but will not commit himself as to their result.

He considers the evidence very strong in favor of this organism being found in the blood of malarial fever patients. It is not, however, a bacterium. Does not think it possible to disinfect the blood by practicable doses of quinine; but does think the drug may be effectual in restraining the ameboid movements, and that they may finally, by arrest of their development, disappear from the circulation.

Dr. Wm. H. Welsh was much interested by Dr. Sternberg's remarks. He agrees in thinking the evidence strongly in favor of these bodies being found in the blood of malarial fever patients. Called attention to an article by Erlich, in which he describes a metamorphosis that takes place in the centre of the red blood-corpuscle, and which takes on stains. This caused considerable doubt as to the correctness of Marchiafava and Celli's discovery; but later publications proved that the body described by them, is an organism.

The organism is known as plasmodium malariæ, it is not a bacterium. He thinks it important, as has been suggested by Koch, that in examining blood and other tissues for organisms, that we do not confine ourselves to searching for bacteria alone.

Marchiafava and Celli produced the disease by inoculating persons free from malaria, with the blood of patients suffering from this malady.

Does not think one justified in drawing conclusions from the result of experiment alone, but is of the opinion that the natural course of events should alway be taken into account.

Since Marchiafava and Celli have not isolated and cultivated this organism and then produced the disease by inoculation from the cultures, he does not

think the etiological role of these bodies *absolutely* established.

Dr. Hiram Woods read a paper on

FOREIGN BODIES IN THE VITREOUS.

Dr. Samuel Theobold thinks it pretty well established that the electro-magnet is superior to the permanent magnet. The so called permanent magnet soon loses its power.

He related a case seen by him some years since. The patient had blown into his eye a bit of glass, a fragment of a test tube that exploded in the course of some experimental work. When seen there was detected a small particle of glass hanging from a shred of iris; in a very few minutes it had dropped into the posterior chamber, and with the exception of a slight temporary imflammation the patient has experienced neither discomfort nor inconvenience since. Vision was absolutely unaffected. The body has now been in the eye about 14 years.

The absence of harm he thinks due to the fact that glass undergoes no chemical changes.

(*To be Continued.*)

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD FEBRUARY 4, 1886.

The President, B. F. Baer, M.D., in the chair.

Dr. Charles Meigs Wilson. Cases of

LACERATION OF THE CERVIX UTERI WITH UNIQUE SYMPTOMS.

The histories of the following cases are brought before the Society in order —first, to record, what the writer believes to be unique symptoms of the lesion, and secondarily to elicit discussion in reference to the reflex nervous symptoms of the lesion and if possible, to draw the line of demarcation between them and the nervous phenomena of alienation. But a few years back we were given the doctrine *ex cathedra*, that lack of contour of the cervix uteri was the principal cause of that train of nervous symptoms, of which the histories here cited contain unique examples. Prior to this the clitoris was supposed to be the source of all the trouble; and now that spaying has become the fashionable surgical procedure, the ovaries have been given the precedence in the causation of the grave reflex nervous symptoms attendant upon pathological conditions of the pelvic viscera. Statistics have pretty well proven that in a large majority of cases destruction of the natural contour of the cervix has been the starting point of pelvic distress in a large number of such cases. The subinvolution with the subsequent conditions of prolapsus, hyperæmia, hypergenesis of tissue, etc., tropion of the cervical mucosa, and the imflammation set up by friction of the everted cervical mucous membrane against the posterior vaginal wall, which frequently occurs in neglected cases of laceration of the cervix, are undoubtedly the primaryfactors of pelvic irritation in many cases, and it is easy to see how this condition may set up pathological conditions of the uterus, Fallopian tubes and ovaries secondarily. To say precisely what is to blame is a very difficult matter. The following cases are selected from a large number operated upon by Dr. E. Wilson in private practice, and by the author in the surgical wards of the Philadelphia Lying-in Hospital.

Case I.—Mrs. McY. æt. 32, married, mother of three children, presented herself at the clinic of the Lying-in Charity with the following symptoms: For the past year, she had noticed a tumor about the size of a small fœtal head in the right lumbar and the right half of the umbilical region. The tumor was perfectly smooth, non-nodulated and freely movable in the abdomen. She had had obstinate constipation, a good deal of vesical irritation; at one time had had a sanguineo-purulent discharge from the vagina; this had entirely ceased for the last seven months. She complained of deep seated darting pain in the lower part of the abdomen, backache, intense cephalalgia and photophobia. Her last last child had been delivered fourteen

months previously with instruments. She had been under the care of a prominent gynæcologist who had diagnosed floating kidney and recommended extirpation. After a careful examination, in which I was aided by several professional friends, the diagnosis previously made was concurred in. A careful chemical and microscopical examination of the urine failed to detect any abnormal constituent. It was then determined that laparotomy for removal of the kidney, or cutting down upon it and stitching in situ would be alike unjustifiable. Upon making a more careful examination, including the uterus, the patient was found to have an extensive bilateral laceration of the cervix. The contour of the cervix was restored; and although the patient still has her floating kidney all her distressing symptoms have ceased.

Case II.—Mrs. S., æt. 32, married, mother of two children; pelvis slightly contracted antero-posteriorly. Both children were delivered alive by forceps. This patient was sent to me, by her regular attendant, with the diagnosis of cancer of the rectum. She suffered greatly from backache and headache, was constipated, passed ribbon stools and had agonizing pain upon defecation. She had slight vaginal discharge, and a coffee-colored, foul smelling muco-purulent discharge from the rectum. Rectal examination revealed an ulcerated surface extending apparently for about an inch and a half in length, completely around the rectum, about three inches above the anus. Small portions of the granular surfaces of the ulcer revealed, under the microscope, no evidence of malignant growth. Specular examination of the vagina showed extensive bilateral laceration with acute retro-flexion. The woman presented no evidence of cachexia. The uterus, though closely bound down by adhesions, was finally restored to its proper axis. After several weeks the contour of the cervix was reformed. Simple astringent applications were made four or five times to the rectal ulcer. The patient made a complete recovery and has had no return of symptoms since the operation.

Case III.—Mrs. C., æt. 22, mother of one child, with history of tedious instrumental labor. This patient suffered from violent ovarian neuralgia, augmented at the catamenial periods. She had a profuse leucorrbœa, engorged uterus and enlargement of the right ovary. She also suffered at times from suicidal dementia, which was sometimes so violent that she required restraint. Her case had been diagnosticated pyo-salpinx and oöphorectomy advised. Examination revealed an extensive bilateral laceration of the cervix, extending on the left side to the vaginal junction. The cervix was restored with complete cessation of all symptoms. Examination six months after the operation, failed to find tenderness or enlargement of the right ovary.

Case IV.—Mrs. S., æt. 37, married, mother of five children. This patient had been incarcerated in a private asylum fourteen months, suffering with violent dementia. She had the typical appearance of alienation. No clear history could be obtained of her symptoms except that she had distressing pelvic pain and profuse leucorrhœa. Examination showed extensive laceration of the cervix. Trachelorraphy was performed with immediate amelioration of the symptoms. Two months after the operation she was restored to her family completely well. A year or more has elapsed since the operation in each of the cases and the relief afforded has thus far been permanent. These cases appear to the author to have unique symptoms, following and consequent upon the lesion, though doubtless, those with more extended chances of observation have met with cases presenting analogous symptoms.

Dr. Joseph Price made some remarks upon the effects of cicatricial tissue in the edges and at the apex of the laceration, of the effect of the laceration in inducing local engorgement and hypertrophy, and thus a long series of consequential symptoms. He spoke of the value of rest and local treatment for the relief of these symptoms, but the relief so obtained is temporary, it will last but a few months, and sooner or later, after the patient is discharged as cured,

the same symptoms recur. If the cicatricial tissue is not all removed,and complete union secured throughout the entire thickness of the cervical tissue, the symptoms will return or even be aggravated by the operation. In his experience, conception results after operation in young women.

Dr. Howard A. Kelly remarked that he was glad to hear of the good results in Dr. Wilson's cases, as a year or more had elapsed. He thought cases of laceration of the cervix might be arranged in three classes. 1st. When the cervix although lacerated remains soft and flaccid there will be no consequent symptoms. 2d. When cicatricial tissue is developed or ectropion is present, marked reflex symptoms will ensue. 3d. When there has been natural repair, but with inclusion or formation of hard or scar tissue, there will also be marked reflex symptoms. To this latter class belong those cases, with hypertrophied glands and everted lips, of so-called erosion. These second and third classes must be relieved by rest and local treatment, and then operated upon to keep them well. Complete removal of the hard tissue, and perfect union of the coaptated edges must be secured. Failure in either of these points will secure a return of the symptoms.

Dr. Baer remarked that the symptoms were not due to the laceration, but to its inflammatory consequences. To secure a good result, the inflammatory condition must first be subdued, and then the operation of closing the laceration will be in order. It may take a long course of treatment to secure this necessary condition, but operation will probably fail to secure the desired relief without the preparatory treatment. I have found, in some of these unsuccessful cases, union of the external surface only, and in others fistulous tracts between the suture points. Cicatricial tissue seems to be sometimes formed after operation when union occurs by granulation. Simple laceration without ectropion is very rare, and he would advise repair of the laceration in all cases to prevent future resultant inflammatory conditions. It is desirable to have union by first intention to avoid formation of cicatricial tissue and suture track fistules.

Dr. Wilson spoke of the choice of method in preparatory treatment. Local treatment once a week will often fail to have a good effect when a week or ten days in bed, with douches of hot water and glycerole of tannin or pledgets of cotton applied daily, will accomplish rapid relief of the local condition. Great care should be exercised in the removal of tissue as complete closure of the cervical canal may happen. He has seen two such cases, which were detected at the next menstrual periods after the operation. The passage of of a spear-pointed probe gave vent to dark grumous material.

Dr. Howard H. Kelley exhibited a specimen of

HÆMATOMA OF THE OVARY WITH THE ADHERENT FALLOPIAN TUBE.

This specimen is an example of a class of cases which stand peculiarly by themselves; cases of aggravated tubal and ovarian disease, on a small scale as compared with ovarian cyst, and yet in which there is enough change in the size and consistency in one or more of the structures of the appendages to afford most satisfactory ground for diagnostic precision under skilled bimanual examination. These cases occupy a middle ground between the larger tumors, where disease is so palpable, and those hap-hazard attempts, the present reproach of gynecological surgery, in which the operation upon appendical structures is undertaken to relieve a *symptom*, and the diagnosis of pathological ovarian or tubal change is made after removal or not at all.

This is the right ovary of a patient 21 years of age. It is about the size and shape of a large Spanish chestnut. I was able to handle it freely by bimanual examination and determined exactly its size, shape, consistency and relations before operating. The indications for operative interference after I had made my diagnosis were greater than in the case of any large ovarian

cyst I have ever seen, and the prospects and results of any form of palliation were futile. Almost the whole of this large ovary is filled with a blood clot, soft and jelly-like in part and in part firm, fibrous and apparently intimately united to the ovarian stroma. This clot is surrounded by a shell of apparently normal ovarian tissue, throughout which are seen a number of follicles and old corpora lutea. A remarkable feature is the way in which the fimbriated extremity of the tube is spread out like a sucker over the surface of the ovary and glued fast by adhesions, so that the line of demarkation between tube and ovary is but faintly indicated. From the line of junction numerous vessels course in a radiating manner down over the ovary. The left ovary is below normal size, but contains many pea-sized black clots.

The second specimens which I now exhibit were removed this afternoon. The case is an example of the third class, in which the operator has nothing but a symptom to guide him. My patient, 35 years of age, suffered from an increasing menorrhagia for 14 years. Lately she has been bleeding half the time. She has had recourse to every possible plan of treatment with but slight and temporary relief. The only thing I could do was to perform oöphorectomy and stop her menstruation. One ovary weighs 139 grains, the other 103 grains. A beautiful corpus-luteum of menstruation, about two-and-a-half weeks old, shows that the hemorrhages, which retained all along a menstrual periodicity, were in reality menstrual. The tubes are free from disease. In one ovary a globular pellucid cyst lies between the layers of the broad ligament in close proximity to the fimbriæ, the tubo-ovarian ligament being spread out over its surface.

Dr. Wilson called attention to the fact that in the first specimen the tube had been occluded by a tension or twist upon itself.

Dr. Baer remarked that it would be interesting to know the results in Dr. Kelly's last case. In such a case there is of necessity a cause for the hemorrhage; there is no apparent diseased condition of the ovary or tubes sufficient to account for it. Hemorrhages from the uterus are often associated with vegetations upon its lining surface, but these are not always present. He alluded to one case in which hemorrhage continued to be profuse after the removal of the tubes and ovaries which had been very much diseased.

Dr. Price remarked that in this last instance the continued hemorrhage might be the result of body-habit, although the original cause might be removed.

Dr. Harris spoke of a case of fibroid tumor of the uterus with menorrhagia, in which removal of the tube and ovaries gave complete relief.

Dr. Kelley had, eight months ago, removed both ovaries and tubes, and the menorrhagia still continues. In the case operated upon to-day the curette had been used but no vegetations had been found. A strong tincture of iodine applied thoroughly to the inside of the uterus and vaginal packing would quickly stop the hemorrhage for the time, but it would soon recur. Operation was performed to relieve the symptom of hemorrhage by bringing on the menopause and not because the ovaries were supposed to be diseased.

Dr. J. Price exhibited specimens from a case of

PYOSALPINX.

The tube was as large as the finger, and cheesy in consistence, and was easily broken, even by the bite of the hemostatic forceps. The patient was in a typhoid condition, with high evening temperature, emaciation, quick pulse, pain in locomotion. There certainly had been leakage of pus before, but two ounces escaped at the time of removal. Adhesions were numerous, but were cheesy and broke down readily. After the operation there was rapid subsidence of the pulse and temperature with the other symptoms. Free washings of the abdominal cavity through a drainage tube were practiced for a few days. There was a clear history of gonorrhœa. The other tube and ovary were not enlarged.

Dr. Beates remarked that in one

case upon which he had operated repeated attacks of peritonitis had caused large deposits of flaky lymphs in Douglass's *cul de sac*. These were nicely removed by sponging.

Dr. Baer raised the question of the gonorrhœal origin of the salpingitis in Dr. Price's case, which was unilateral, while gonorrhœa usually causes both tubes to become diseased.

Dr. Price stated that Mr. Tait's new book reported a gonorrhœal case of unilateral salpingitis. Comparing with the male analogue epididymitis, which is usually unilateral, would support the idea of such an origin. A free leakage of secretion from the tube, and absence of constriction, may prevent the accumulation of pus on one side.

Dr. Beates exhibited specimens from a case of

DIFFUSED SARCOMA UTERI WITH METASTASIS TO LIVER AND LUNGS.

The patient from whom the specimens were obtained was in excellent health until the development of this affection. Æt. 59. Catamenia established during the 16th year without undue disturbance. She has had four children and no miscarriages or pelvic disease during her sexual life. There is no evidence of heredity toward myoplastic disease. Menopause at age of 48, without incident. About five years later a hemorrhage occurred lasting a few days. It recurred with decided regularity, and the patient believing it to be menstrual did not have recourse to treatment until an intermenstrual sero-sanguinolent discharge appeared. Later this assumed a purulent type, and was accompanied by constant pain. The condition was now regarded as carcinomatous. In June, 1885, I found the patient emaciated, cachectic and weak; digestion was impaired and the stomach irritable. Local pain was intense, with nocturnal exacerbations; there was also incontinence of urine and its consequent intertrigo. The vagina was so occluded with numerous neoplasms, ranging in size, from mere nodules to the size of an olive, that an examination of the uterus was impracticable. Some of these were pedunculated. There was an offensive ichorous discharge; bleeding occurred upon the slightest touch. The history was one of progressive asthenia.

The *autopsy*, by Dr. Formad, disclosed the pulmonary apices and inferior posterior margins to be the seats of nodular masses. The surface of the left hepatic tube was the seat of two deposits which simulated encephaloid carcinoma. The lymphatic glands were perfectly normal. The uterus was enlarged about one-fourth, and its attenuated walls were easily torn; upon opening it, it was found to be almost entirely destroyed by ulcerative processes, which were most marked near the fundus. The cavity of the pelvis was occupied by the morbid mass and the vagina entirely destroyed. The bladder was not involved, but the uretha was sloughed through; rectum free. The microscope showed a small-cell sarcoma. The pathological laws of which this is an illustration possess especial interest regarding treatment. It is now well known that neoplasms originating in areas that have developed from either the epi, meso, or hypoblast possess certain specific life histories, and while all may closely resemble each other in their incipiency differ widely not only in their course but ultimate results, as they continue to exist. Thus epithelioma of epiblastic structure is local and not subject to metastasis, while the hypo-blastic epithelimata are pre-eminently metastatic. Mesoblastic neoplasms are of connective tissue type, and in large cell forms local, while in small cell varieties metastatic. Epitheliomata undergo metastasis through the lymph channels; sarcoma, by means of the blood vessels. Either of these diseases when first becoming active, there is good reason to believe, is local, and before retrograde changes occur can, by total removal of the organ involved, be radically cured. As sarcoma, and especially its small-cell variety, is especially prone to metastasis, its early recognition is a matter of paramount import. In this case its early evidence was mistaken for carcinoma, and from a clinical standpoint alone

such an error is unavoidable, but as the discharges contain portions of the neoplasm, readily recognized by the microscope at a time when metastasis has not occurred, its diagnosis and treatment are a matter of simplicity. The later symptoms, absence of lymphatic involvement and comparatively slow course, enable one to know that he is palliating the sufferings of a sarcoma.

W. H. H. Githens, Sec.,
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TRANSACTIONS OF THE GYNÆCOLOGICAL SOCIETY OF CHICAGO.

REGULAR MEETING, 18TH DECEMBER, 1885.

I. Jaggard. *Two Recent Models of the Axis-Traction Forceps.*

II. Byford. *Report of a Case of Pelvic Abscess, with Remarks upon the Treatment.*

The President, Daniel T. Nelson, M.D., in the Chair.

I. *Dr. W. W. Jaggard* read a paper entitled

TWO RECENT MODELS OF THE AXIS-TRACTION FORCEPS.

The object of the paper was not the description of some modification by the writer, although such a contribution to the literature of the subject would be perfectly legitimate in view of Pajot's witty remark to the effect "that he does not reproach a man for having invented a forceps, since that might happen to any one."—(*Barnes.*)

Breus and *Felsenreich*, formerly assistants respectively in the third and first obstetrical clinics of the Vienna General Hospital, have recently made important alterations of Tarnier's axis-traction forceps. The importance of these modifications was so great that no apology was demanded for calling attention to the instruments.

HISTORICAL.

As the result of the labors of Sir J. Y. Simpson, Nägele, Busch, Levret and others, the low forceps operation may be regarded as a comparatively perfect operative procedure, both as regards instruments and mode of operation. The case is different with the high forceps operation. This operation is always difficult, and sometimes dangerous, with the instruments mentioned. The cause is obvious. The applied force can be resolved into two components, one in the direction of the axis of the plane of the inlet, the other perpendicular to the first, directed towards the posterior surface of the symphysis. The first component is alone active in causing the descent of the head; the second makes the extraction more difficult and exposes the maternal tissues between the head and symphysis to traumatism. As remarked by Schauta, (*Grundriss der Operativen Geburtshilfe*, Wien, 1885, p. 162,) "the unphysiological and therefore mischievous element in the operation of the forceps, as compared with the effects of uterine contractions, when the head is at the inlet, consists in the fact that the forceps draws the firmly-held head in a direction which it can never follow, while the uterine contractions simply drive the head into the pelvic cavity, and permit it after that to seek the direction of least resistance." The older obstetricians, fully recognizing these facts, attempted to apply the power to the classical forceps, in such a way as to secure a more favorable direction of traction. Osiander (1799) and Stein, Sr., (1805) may be mentioned among the older obstetricians, who devised instruments for making traction in the axis of the inlet. Hermann (1844). (Kilian's *Armamentarium lucinæ novum*) constructed an instrument, in which an iron lever is attached to the lock. J. P. Hubert (1860) attached a vertical iron lever to the extremities of the ordinary forceps. This lever was subsequently attached to the lock. Eugéne Hubert, his son, constructed an axis-traction forceps with parallel branches and a sharp perineal curve. Chassagny, Joulin, Pros, Poullet, Moralès Apaca (1871) and others have constructed various types of axis-traction forceps at a more recent period. In many of the modern French

instruments an attempt has been made to apply some of the well-known principles of veterinary surgery.

TARNIER'S FORCEPS.

In 1877, Tarnier, following in the wake of Hermann, Hubert, and more recent French inventors, constructed and published a description of his well-known instrument. Since that time, he has produced more than thirty distinct models. His last model consists of the classical forceps of Levret, (without a perineal curve) and axis-traction rods attached to the posterior, inferior border of the blades or spoons. Tarnier claims a number ot advantages for his instrument over any other axis-traction forceps. He claims that it is superior to the classical instruments in the following particulars:

1. It is possible to apply traction in the direction of the principal pelvic axis.

2. Sufficient mobility is conferred upon the child's head to permit it to seek its way through the pelvis in the direction of the least resistance.

3. The handles indicate to the operator the direction in which traction should be made.

With reference to the first proposition, it may be said that traction with Tarnier's forceps is not made in a curved line, accurately coincident with the principal pelvic axis, when the head is at the inlet. Nor is the traction in this direction absolutely necessary, as remarked by Schauta, seeing that the resultant of the forces, developed by uterine contractions, and the resistance opposed by the pelvic floor, does not propel the head in the direction of the principal pelvic axis.

The handles, as indicators of the direction in which traction should be made, are of relatively slight value.

On the one hand, the operator who is at all qualified to apply the forceps at the head of the inlet, ought to have a correct conception of the direction in which traction should be made. On the other hand, strict attention to the handles may prevent the operator from observing a number of important events, ex. gr., the relation of the head to the vulva, slipping of the instrument, etc. (Schauta)

Finally, the handles are not a correct indicator of the direction of the principal pelvic axis.

The advantage of Tarnier's forceps over its predecessors lies in the mobility conferred upon the fœtal head by the joint uniting the blades and the so-called axis-traction rods. The head does not follow the direction of the principal pelvic axis, but seeks the path of least resistance. In consequence, the operator is spared the fatigue of unnecessary effort, and the mother, the dangers of traumatism from violent traction.

I. *Breus* has recently constructed an instrument which has a great advantage over the forceps of Tarnier, in that a greater degree of mobility, during traction, is conferred upon the head.

The continuity of the blades (*Löffel*) is interrupted at, and below, the fenestræ, by a strong flat joint, which admits of movements in the sagittal direction, and corresponding variability in the angle at which traction is applied to the head. The superior ribs of the instrument are prolonged, and turned upward like spurs. These spur-like prolongations are joined by a metallic rod in order to preserve a certain parallelism of the blades.

Apart from these peculiarities, the instrument is identical with the original model of Sir James Y. Simpson's forceps.

This instrument, devised by an obstetrician of large experience, is employed on an extensive scale at Vienna, in Gustav Braun's obstetrical clinic. Schauta (*Grundriss der Operativen Geburtshilfe*, Wien, (1885, p. 164 et seq.) recommends the instrument as the most perfect axis-traction forceps in existence, to his classes at the University of Innsbruck. Fürst's recent favorable note on Breus's forceps in the *Centralblatt für Gynækologie*, 1885, is well known.

II. FELSENREICH'S MODIFICATION OF DR. ALEXANDER SIMPSON'S MODIFICATION OF TARNIER'S AXIS-TRACTION FORCEPS.

In 1880, Doctor Alexander Simp-

son, of Edinburgh, sent to Dr. Carl Braun a modification of Tarnier's axis-traction forceps, which at once superseded the French instrument in the first obstetrical clinic of the Vienna General Hospital. Simpson substituted Sir J. Y. Simpsons's original model of the classical instrument for Levret's. The compression-screw is located on the upper third of the superior surface of the handles. Comparatively unimportant modifications were made with reference to the traction-rods, and the hard-rubber handle, into which the traction-rods fit. Felsenreich has materially enhanced the value of Dr. Alexander Simpson's instrument by a number of important alterations.

Felsenreich's modification of Dr. Alexander Simpson's axis-traction forceps, as shown by the model presented, manufactured by Mr. J. Leiter, of Vienna, during October, 1885, consists of the following parts:

I. A practically unaltered model of Sir James Y. Simpson's forceps (*Wiener Schulzange.*)

II. Button-hole perforations, one behind fenestra, into which traction-rods are inserted, and maintained by the buttons on the ends of the rods.

III. A removable compression thumb-screw, which sinks into a groove made in the extremities of the handles of the Simpson forceps.

IV. A hard rubber-handle for the traction-rods. The arrangement for the insertion of the traction-rods into the hard-rubber handles differs from the mechanisms in Tarnier's and Alexander Simpson's axis-traction forceps.

The attachment of the compression-screw to the ends of the handles, and certain changes in the curve of the axis-traction rods have been made at a comparatively recent period, but prior to 1883.

Dr. E. L. Neale, of Baltimore, published an article in the September number of the *American Journal of Obstetrics*, 1885, entitled "An Obstetric Forceps." In this paper Dr. Neale describes an axis-traction forceps, devised by himself, which differs in no essential particular from Felsenreich's modification of Alexander Simpson's instrument. Editorials have appeared in the *Journal of the American Medical Association*, 26th September, 1885, and the *Therapeutic Gazette*, 15th December, 1885, calling attention to the facts, that a forceps, identical with the instruments devised by Dr. Neale in all essential details, had been constructed several years before in Vienna by Dr. Felsenreich, and that Dr. Neale had probably forgotten the existence of that instrument, although he had seen it in active operation in the lying-in-ward of Carl Braun, in various courses on operative obstetrics, and in the shop of Mr. J. Leiter, the instrument-maker to the Vienna General Hospital. The only criticism that the writer would make, with reference to these editorial notes, was, that Dr. Felsenreich, not Dr. Neale, applied the compression thumb-screw to the ends of the handles. Dr. Neale has made some trivial modifications in the hard-rubber handle and mode of insertion of the traction-rods. Dr. Neale made no allusion to Alexander Simpson's modification of Tarnier's instrument in the paper mentioned, and his allusion to Dr. Felsenreich's suggestion of the button-hole joint is, to put the case very mildly, disingenuous.

In conclusion, Dr. Jaggard said that he was of the opinion that the axis-traction forceps of Breus and Felsensenreich were superior to the most recent model of Tarnier's, or any other axis-traction forceps that had come under his observation. He requested that the discussion be limited to the comparative merits of the forceps presented—Breus's and Felsenreich's—and other recent models of the axis-traction instrument.

DISCUSSION.

Dr. John Bartlett said that he had devised an axis-traction forceps in 1880, identical in principle with the instrument constructed in 1860 by the elder Hubert. His attention had been called to the coincidence by Dr. Lahs's monograph on *Die Achensenzug-Zangen*, Stuttgart, 1881.

Dr. Henry T. Byford thought the instrument described by Dr. Neale in the September number of the *American Journal of Obstetrics*, 1885, was identical in all essential particulars with Felsenreich's modification of Alexander Simpson's instrument devised two or three years before.

Dr. Philip Adolphus, *Dr. A. Reeves Jackson*, *Dr. H. P. Merriman*, *Dr. H. P. Newman* had never observed indications for axis-traction forceps; had never employed such instruments, and thought they were unnecessary.

Dr. Jaggard said he had no desire or intention to discuss the general subject of axis-traction forceps, and had expressly requested that the discussion should be limited to the consideration of the relative merits of the instruments presented for examination, (Breus' and Felsenreich's) and other modifications of the axis-traction forceps. He thought that gentlemen of limited experience in cases indicating the high forceps operation, and particularly those who had absolutely no experience with axis-traction instruments, should be temperate in their criticisms. Carl Braun, Pajot, Charpentier and others had practically rejected such instruments, but only after serious and experimental consideration of their merits. On the other hand, many younger obstetricians, including Schauta, Felsenreich, Breus, Ehrendorfer, thought there were cases in which they might be profitably employed.

(*To be continued.*)

Subcutaneous Injection of Blood.—Von Ziemssen (*Arch. f. Klin. Med.*) makes an interesting contribution to the subject of blood-transfusion. The fact had been pretty well established that it was possible to introduce blood into the circulation through the subcutaneous tissue, and to cause in this way an increase both in the amount of hæmoglobin and in the number of blood-corpuscles contained in the receiver's blood; but what effect repeated injections of small quantities of blood had on the composition and efficiency of the depraved human blood was a question which had hitherto remained unanswered. He has therefore had recourse to the subcutaneous injection of small quantities (50 ccm.) of defibrinated human blood, injecting 25 ccm. into each thigh, and then estimating, by means of Vierordt's spectral apparatus, the changes which take place in the amount of hæmoglobin of the blood. He found there was a distinct rise in the amount after injection, reaching a maximum in course of the first 24 hours; there was then a gradual fall towards the previous amount, but never so low as the original level. After a second injection a still higher level was permanently reached, so that by repeated injections the amount of hæmoglobin in the blood of the patient could be actually or even more than doubled. No bad symptoms follow the injections, neither fever nor hæmoglobinuria, and even local tenderness was only present in a few cases and lasted only for a day or two. On the contrary, even after the injection of small quantities (50 ccm.) improvement soon showed itself in the form of more natural color of the skin and mucous membranes, and in the promotion of sleep, appetite, and general bodily and mental vigor. The number of injections made was generally one or two in the course of two weeks, sometimes, however, four or five. He gives two cases—one of scurvy, and the other of marasmus in a child aged eight—in both of which the results obtained were very rapid and satisfactory. He therefore strongly recommends this method of transfusion in cases of idiopathic anæmia and chlorosis; in anæmia the result of puerperal, intestinal, or traumatic hæmorrhages; and in leucocythæmia and progressive pernicious anæmia. One of the most essential precautions, after cleanliness, to be taken in carrying out the transfusion, one whose object is the prevention of any formation of a local blood tumor, is the performance of gentle massage, drawing the fingers upwards over the skin, during the whole period of injections and for a few minutes after its completion. In this way the blood is well driven into the recesses of the subcutaneous tissue, and tendency to local inflammation or abscess formation is avoided.—*London Practitioner*

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BALTIMORE, FEBRUARY 20, 1886.

Editorial.

THE TREATMENT OF PELVIC ABSCESS IN WOMEN.—Pelvic cellulitis and peritonitis are sufficiently common conditions in women to have attracted a great deal of clinical study among gynæcologists. The literature of these conditions is full and exhaustive, and the treatment has been outlined in letters as bright as sunbeams. When we enter upon the pathological study of these conditions we stumble upon theories and views as many colored as the rainbow.

It is fortunate for woman, kind that in the far larger proportion of cases of pelvic inflammation resolution takes place with a gradual absorption and complete disappearance of the exudation leaving either no traces or only a slightly arrested mobility of the uterus. This is a happy escape from the numberless ills which seem to surround the unfortunate patient whose pelvic tissues are permanently altered by the products of pelvic inflammation. It is so common now-a-days to refer the troubles which are incident to woman to chronic pelvic inflammation that one, not thoroughly familiar with the diseases peculiar to women, might well conclude that cellulitis and peritonitis are hobbies which many gynæcologists ride, and that the terms, if not the conditions which they represent, were coined to offer a ready explanation for symptoms which can not be referred to their appropriate pathological causes. We would not attempt to undervalue the significance of pelvic cellulitis and peritonitis as disturbing factors of female health, or as important pathological conditions worthy of careful and intelligent treatment. We regret, however, the too free use of the terms, and the rather vague way in which they are made to account for symptoms which may have reference to entirely different pathological causes. But whatever be the ambiguity which surrounds the explanation of those conditions which are referred to the diseases resulting from a pelvic inflammation, this indefiniteness becomes an intelligent pathological fact when a pelvic abscess is the sequel disclosed. The rapid breaking down of an exudation and the formation of an abscess is the uncommon exception in pelvic inflammations. It is more frequent as a sequel of cellulitis than of peritonitis, and is usually met with in patients whose recuperative powers are below par. According to Mundé it probably does not occur in more than ten cent. of all cases, the majority of exudations terminating in spontaneous absorption. The pus formation may be either intra or extra-peritoneal, but the latter site is most commonly selected from the fact that the pelvic cellular tissue is most frequently involved. This circumstance is the more fortunate from the fact that treatment can be more satisfactorily applied than when pus formations take place high up between pelvic viscera and intestines. In a recent paper on the "Treatment of Pelvic Abscess in Women by Incision and Drainage" (*American Journal of Obstetrics*, February, 1886,) the author, Dr. P. F. Mundé, of New York, sums up a number of practical suggestions quite worthy of consideration. Among 400 cases of pelvic peritonitis and cellulitis, Dr. Mundé observed 48 cases of pelvic abscess, 21 of which were seen in consultation and 27 occurred in his own practice. Of these 48 cases, 23 opened spontaneously, 14 into the rectum, 5 into the vagina, 3 into the bladder, and 1 through the abdominal walls. Sixteen were treated by aspiration and eight by free incision and drainage, 6 through the ab-

dominal walls and 2 through the vagina. From this experience Dr. Mundé concludes that small deep-seated pelvic abscesses, not exceeding a capacity of two ounces, and minute multiple abscesses in the cellular tissue, can often be cured by evacuating the pus thoroughly with the aspirator. Abscesses containing more than two ounces, he advises, should be opened by free incision along an exploring needle or grooved director, cleared of debris by fingers or blunt curette,and drained or irrigated, if necessary, through a drainage tube. This incision should be made where the pus points most distinctly, which is usually the vaginal vault. We quite agree with Dr. Mundé in his opinion as to the necessity for free drainage in these cases, as also in the statement that the opening of a pelvic abscess, which points through the abdominal wall does not differ from, and is no more dangerous, than, the same operation elsewhere on the cutaneous surface of the body. "It is not an 'abdominal section' or a 'laparotomy' in the sense that these terms are now used to indicate the surgical opening of the paritoneal cavity." In those cases where abdomino-cutaneous drainage will not suffice the counter-opening through the vagina, with a drainage tube carried through the two openings, seems to us to be not only rational, but a necessary procedure. The chief object to be secured in these cases of deep and large abscess cavities is thorough drainage and cleansing with antiseptic and stimulant irrigations. This object may be attained in a certain number of cases. The practice seems worthy of careful employment. The results secured by Dr. Mundé confirm this opinion.

Whilst the local treatment of chronic pelvic abscesses demands the patient attention and skill of the surgeon, the constitutional treatment should not be ignored or overlooked. These patients require good food, fresh air and favorable surroundings, with a liberal allowance of iron, quinine, and, in certain cases, cod liver oil and stimulants. In those fortunate cases where abscess formations make their own outlet, and then undergo resolution, the result is happy enough for self congratulation.

Miscellany.

A Correction.—Hyoscine Hydrobromate.—In the issue of this Journal of Feb. 13th, we are requested to make the following corrections in the article on Hyoscine Hydrobromate, by Dr. E. M. Schaeffer. On page 311, line 10, read, "Now and then there is no enlargement of the pupil noticed," and on same page, line 14, substitute "no" for "the" in the sentence, so as to read "No unpleasant effects, such as nausea, headache, loss of appetite, etc., have occurred in our experience."

Dr. Schaeffer also wishes the following statement made: "I may add that in one instance of slight giddiness nausea has since been noticed—the patient remarking it after breakfast—possibly from the effects of a preceding night dose of gr. $\frac{1}{70}$.

Dr. Bartholow (*Materia Medica*, last edition, p. 451) speaks as if headache and vertigo followed deep and quiet sleep resulting from hyoscine quite naturally.

In more impressionable subjects than mine, perhaps, it may; though I have used it in the insomnia of rational patients also."

Pills for Neurasthenia.—Maximovitch ("Revue de thérapeutique médico-chirurgicale"; "Union médicale du Canada", Jan., 1886) is credited with the following formula:

Bromide of iron, } each,
Hydrobromate of quinine, } 1 drachm;
Extract of rhubarb, a sufficient quantity.

Divide into 120 pills, two of which are to be taken three times a day.—*New York Med. Journal.*

Hypodermatic Quinine.—Dr. S. S. Burt says in the *Quarterly Bulletin of the New York Post-Graduate Medical School:* "For those who are obliged to administer quinine subcutaneously, it is desirable that the solution should be as little irritating as possible. Lente's solution consists of bisulphate of quinine 50 grains, dilute sulphuric acid 100 mm., and carbolic acid 5 mm. to an ounce of water. He apparently did not know that

the bisulphate is quite soluble in water without the addition of dilute sulphuric acid. Having made use of the following formula, I can recommend it:

℞. Quiniæ bisulphatis - - gr. lx.
Acid boracic - - - - gr. ij.
Morphiæ sulphatis - - gr. ¼.
Aquæ distil - - - - ʒ j.

Sig.: For hypodermic use. One drachm. contains seven and a half grains of quinine.—*Medical Record.*

A Mixture for Gastro-Intestinal Atony.—The following formula is given in "Nouveaux remèdes" (quoted in "Union médicale du Canada," Jan., 1886):

Tincture of nux vomica - 2 parts;
Fluid extract of *Cascara Sagrada* - - - - - 20 "
Syrup, Cherry-laurel water, - - each. - 15 "
Distilled water - - - 10 "

Three or four teaspoonfuls to be taken daily.—*New York Medical Journal.*

Medical Items.

Dr. Amèdèe Dechambre, the editor of the *Gazette Hebdomadaire*, died on the 4th of February, at the age of 75 years.

The total Hospital Saturday and Sunday collections last year in Baltimore, were $2,657.31.

Dr. Burton Randall, an old and highly respected Army Surgeon, (retired) died in Washton, D. C., on the 8th of February.

Mr. William Dalby, aural surgeon to St. George's Hospital, has recently received the honor of knighthood.

The *Medical Record* states that there are not over fifteen Homœopathic physicians in the whole limits of the State of Virginia, yet a bill has been introduced into the Legislature of that State to create a Homœopathic Board of Medical Examiners.

M. A. Fort ("Union Mèdicale," Jan. 16, 1886) is credited with the following formula:

Potassium iodide - - - 5 drachms;
Potassium bromide - - 75 grains;
Syrup of gentian - - - 18 ounces;
Tincture of iodine - - 20 drops.

A tablespoonful to be taken, morning and evening, in chronic articular rheumatism, and the affected joints to be painted with tincture of iodine.—*N. Y. Medical Journal.*

Dr. Schaltz reports a case (*Centralb für Gynak.*) of a young woman who conceived and gave birth to a child at full term, after having suffered a removal of the whole left ovary for a cystic tumor, and also a part of the right ovary which had undergone cystic degeneration.—*Medical Record.*

Cocaine has fallen so rapidly in price that it is now said to be worth only three pence a grain in England. It is a far less expensive luxury in this country than it was a few months ago, but it still remains higher in price than is desirable for its many useful purposes.

M. Pasteur states that every dog, whether he eats or not, that is attacked with hydrophobia, dies in a few days. When it eats, death is delayed a few days, but that is all. It cannot live for more than ten days. During that interval the rabid symptoms will be shown. His advice is to lock up or chain the dog supposed to be rabid, be careful in feeding him, and avoid being bitten. If the dog survives the tenth day he may be regarded a harmless animal.

The course of Lectures on Micro-Organisms in Disease, given each Wednesday evening during the present month, under the auspices of the Johns Hopkins University, by Prof. William H. Welch, has attracted considerable interest and attention. These Lectures will continue until March 31st. They are well worthy of being heard. Special cards of admission can be obtained upon application to the University authorities.

Dr. Alfred C. Post, the well-known Surgeon, died at his residence in New York City, on Feb. 7th, after a brief illness. Dr. Post was born on January 13, 1806, and was therefore 80 years of age at the time of his death. He continued in active practice up to the advent of his recent illness, and was noted for his untiring energy and industry in his profession. He was elected to the Chair of Surgery in the University of the City of New York in 1851, and held this position until 1875, when he was made an Emeritus Professor. He is said to have led an exceedingly useful and unselfish life, being equally devoted to his profession and to the Christian faith.

The *New York Medical Journal* says that it is rumored that Dr. N. S. Davis, the venerable editor of the *Journal of the American Medical Association*, has lately been attacked with hemiplegia, and expresses the hope, in which we join, that the rumor may prove unfounded. As the *Journal*, which Dr. Davis edits with so much vigor and enthusiasm, contains no reference to the failure of Dr Davis's health and gives no evidence of any diminution of editorial ability we assume that the rumor is incorrect. Indeed, the last issue of the *Journal of the Association* is one of the strongest numbers we have yet seen and indicates an increase, rather than abatement, of editorial strength and skill. We trust its venerable editor may long live to enjoy the fruits of his earnest labor in his profession.

Original Articles.

DIAGNOSIS OF FIBRO-CYSTIC TUMOR OF THE UTERUS. LAPPAROTOMY AND SUPRA-VAGINAL AMPUTATION OF UTERUS.*

BY A. F. ERICH, M.D.,

Professor of Diseases of Women in the College of Physicians and Surgeons, Baltimore.

Mrs. A. McN., American, age 40 years, widow, entered the Maryland Woman's Hospital, Dec. 15th, '85; married when 19 years old; she has had no children or abortions. She menstruated first when 13 years old, generally every four weeks, sometimes the interval being but three weeks; amount usually small, and the duration four to five days. She is very anæmic. Five years ago she first noticed a hard tumor, the size of a hen's egg, in the lower portion of her abdomen. It grew rapidly during the first two years and a half, since then more slowly. It varied in size, and had lately become somewhat smaller. Has had bloody discharges from her vagina lasting six weeks, and has at times gone as many weeks without any discharge. Has frequently suffered from pains resembling labor. Her health has been gradually growing worse ever since she first noticed the tumor. Has also been subject to attacks of nausea, vomiting and diarrhœa. Physical examination revealed a tumor the shape of an enlarged uterus, extending from the pubes to a little above the umbilicus, movable and continuous with the cervix uteri. The depth of the uterus, as measured with the probe, was five inches. Temperature, pulse, and respiration normal. The consistency of the tumor seeming rather softer than that of a fibroma, the aspirator needle was introduced, and about a fluid drachm of a colorless, serum-like fluid was obtained, which, upon microscopical examination, (by Dr. Keirle) did not furnish any characteristic appearances that were calculated to assist in the diagnosis. The aspiration was not followed by any unpleasant effects. The diagnosis arrived at was: Interstitial Fibro-cystic tumor of the Uterus, adopting the definition as given in *Prof. Th. Billroth's* "Handbuch der Frauen-Krankheiten, Band I., Abschnitt III, Seite 102," according to which, all fibroid tumors that contain collections of fluid within their stroma are fibro-cystic tumors. These include lymphangioma, myoma telangiektodess. cavernosum, (Virchow) and myxomyoma, of which latter Gusseion says, (page 103 of Billroth's work, above quoted) that microscopically it would be difficult to distinguish this form from sarcoma. The great danger of supra-vaginal amputation of the uterus (the only radical cure of the case) being fully stated to the patient, she elected to take the risk, rather than to continue to lead the life she had been leading. The patient being extremely anæmic, the palpebral conjunctiva being perfectly white, she was put upon a preparatory treatment consisting principally of good food, iron and quinia, until, after the expiration of six weeks she seemed to be strong enough to make a successful operation possible. The operation was done, Feb. 1st, under all the usual antiseptic precautions, and occupied three hours. The abdominal incision made in the lenea alba, extending from an inch and a half above the pubes to the umbilicus, had to be extended to a little over an inch above the umbilicus before the enlarged uterus could be rolled out. Both ovaries, considerably enlarged, rolled out with it. Finding the diagnosis verified and no adhesions present, an Esmarch gum tube of the thickness of a little finger was tied firmly around the cervix, as low down as practicable, including (1. Geschwulstlehre III., p. 124) a considerable portion of the broad ligaments. The greater portion of the uterus was then removed, taking care to leave enough of the cervix to prevent the gum tube from slipping. The broad ligaments were next secured by ligatures before they had time to slip from under the gum tube, which they are apt to do. As much of the cervix as could be carefully removed was then trimmed out in the

*Read before the Gynæcological and Obstetrical Society, of Baltimore, February 9th, 1886.

shape of a funnel, with thin edges. These edges were brought together antero-posteriorly by—first, a row of deep sutures to prevent bleeding, and, second, a row of superficial sutures to bring the edges of the peritoneum in good apposition. Being unwilling to trust a mass ligature around so thick and rigid a stump as the remnant of the cervix presented, much time was spent in arresting hæmorrhage from the stump by introduction of deep sutures. The rubber tube had to be loosened and tightened many times before all the bleeding points had been thus secured. The blood lost during the whole operation could not, however, have amounted to more than a few ounces. The vagina was then carefully washed out with the bichloride of mercury solution, an opening made at lowest point in Douglas's *cul-de-sac*, and a rubber drainage tube, provided with a cross-bar, to prevent it from slipping out, and long enough to reach from this space to the vulva, inserted. The vagina was filled with salicylated cotton and the external opening of the drainage tube covered with the same material in order to exclude the air. The abdominal incision was closed, in the now usual manner, deep and superficial silk sutures, and dressed antiseptically. Fully realizing the gravity of the operation, only such assistants as were absolutely necessary were admitted to the operating room, in order to make the risk from infection as small as possible. Prof. Rohé administered the ether, and Dr. Clark, the Resident Physician, the three House Students, Messrs. Lindley, Wise and Robertson, with the Matron, Mrs. Warner, all dressed in freshly washed linen, were all that were permitted to be present. The subjoined pulse and temperature chart furnishes the subsequent history in a condensed form. Dr. Keirle's report of the necropsy gives as the cause of death, cardiac asthenia, and thrombosis, and says that the heart was so flabby as to flatten out of shape when laid upon the table. His report also shows that there was no secondary hæmorrhage, that the drainage had been efficient, and that septicæmia had been prevented, as shown by the absence of decomposing fluid in the abdominal cavity, the temperature and pulse changes, and the fact that a firm clot of blood was found in the heart and pulmonary vessels, while after death from septicæmia the blood is generally found of the consistency of tar. The manner of operating was that described by A. Martin in his "Pathologie und Therapie der Frauen-Krankheiten," with such slight modifications as personal experience suggested, or were made necessary by the conditions under which the operation was done. Martin places a ligature around the cervical stump, to which, with my experience with a cat-gut tourniquet in cervix operations, I felt I had no right to trust the life of the patient. As I was not able to procure a drainage tube provided with a crossbar, as he describes, I was compelled to extemporize one by cutting a hole through a gum tube near its end, and then forming a crossbar by splitting a small piece of the same tube and passing one of the pieces through the holes found at the upper end of the drainage tube. This piece, turned with its concave surface downwards gave an opening on each side of the tube immediately under the crossbar. The opening in Douglas's *cul-de-sac*, for the passage of the tube, was made by pushing the point of a uterine dressing forceps, with a boring motion, through the peritoneo-vaginal septum, from the vagina into Douglas's space, the fingers of the left hand being used to make counter-pressure. This instrument being so very blunt, the opening was made without the loss of blood. The lower end of the tube was now seized between the blades of the forceps and drawn down until its crossbar rested upon the floor of the space. The necessity of the tube was made manifest by an almost constant dribbling of bloody serum during the first twenty-four hours. The tube was removed on the morning of the fourth day. In reference to the condition of the abdominal cavity, Dr. Keirle reports: "There was no attempt at union of the abdominal incision, the lower half of which is discolored. The stump of the uterus is observed, united by sutures and lymph. Injection with two-

ounce glass syringe, nozzle introduced through cervical canal, does not, until after fourth trial, spirt in three fine jets through incision." Around the opening made for the drainage tube he found "a layer of lymph (fibrin), of irregular surfaces, which extends thence on the pelvic peritoneum 2 c. m. area. Fibrin also agglutinates some coils of small intestines to uterine stump. This is a limited pelvic peritonitis. No further inflammation exists in the abdominal cavity, in which the other organs and structures are normal." The tumor was imbedded in the anterior wall and fundus of the uterus. The thickness of the anterior wall being six inches, that of the posterior only three quarters of an inch, weight of whole uterus and tumor, three pounds and eight ounces. Upon section the tumor presented a pink colored, transparent tissue, seemingly consisting of a delicate network of fibres and capillary vessels separated by transparent fluid, looking very much like a section through connective tissue in œdema, and corresponding very nearly to a description of myxomyoma as given by Virchow. Dr. N. G. Keirle, the pathologist to the hospital states:

* "Its microscopic histology is that of the medium-sized spindle cell sarcoma."

	Temp.	*Pulse.*
FIRST DAY.		
6.30, P. M.	96.	120.
9.30, P. M.	98.	108.
SECOND DAY.		
10.00, A. M.	101.	110.
4.00, P. M.	100.	114.
10.00, P. M.	101.6.	130.
THIRD DAY.		
10.00, A. M.	102.2.	120.
4.00, P. M.	100.8.	130.
10.00, P. M.	101.	114.
FOURTH DAY.		
10.00, A. M.	103.	120.
12.30, P. M.	104.	150.
2.30, P. M.	104.8.	Imperceptible.
2.13, P. M.	Death.	

*The microscopical examination was made after the case was reported.

HÆMIC MURMURS.*

BY GEORGE J. PRESTON, M.D., OF BALTIMORE

Hæmic murmurs are so designated from the supposed instrumentality of the blood *per se* in their production. These murmurs are heard at the base of the heart and along the great vessels in the neck, rarely elsewhere. The arterial hæmic murmur is short, generally feeble and always systolic or post-systolic in time, and heard best low down in the neck.

The murmur is usually low-pitched, and blowing, heard most distinctly in the the upright position, often disappearing when the patient is recumbent.

There seems to be no definite relation between the arterial and venous murmurs, for they may both be heard simultaneously, or only one be detected. The venous murmur, or *Bruit de Diable*, differs from the arterial in being continuous and of a higher pitch. It is humming, or singing, recalling the sound made by the wind, now high, now low, with various intonations and sometimes musical.

The seat of this murmur is almost exclusively in the internal jugular, though some observers have noted it in other large veins. It, like the arterial murmur, is heard best in the upright position and with the head turned slightly to one side. It has been noted by Southam and others that this murmur can be made to vanish completely by putting the neck upon the stretch. In other subjects, where the neck is long, this murmur may be artificially produced by nice compression with the stethoscope.

Where the murmur is present, care must be exercised not to make too forcible compression and so stop the blood flow. The murmur is sometimes heard satisfactorily without the aid of the instrument. Occasionally this venous murmur is intermittent, though the intermissions, as Guttman observes, are generally produced by respiration, and disappear on the discontinuance of that act.

*Read before the Clinical Society of Maryland, January 22, 1886.

Closely allied to these vascular murmurs is the functional or non-organic murmur heard over the heart. The most frequent seat of this murmur is over the pulmonary orifice, and, according to most authorities, rarely heard over the mitral area. The character of this murmur is identical with the arterial murmur, soft and blowing, and rather short and systolic in time. The general conditions under which one or all of these murmurs is heard are exceedingly various; anæmia, in its several forms, chronic malaria, typhoid and typhus fever, sometimes variola, very frequently relapsing fever, and a number of other exhausting diseases.

No post-mortem lesions have ever been made out. The cause of these murmurs has never been distinctly understood, for it is a subject admitting of very little experimental proof. Lannaec ascribed them to a spasm of the arteries. Sir Dominic Corrigan enunciated the theory that a murmur was caused by the passage of blood from a smaller to a larger tube, and illustrated this by forcing water through a gut constricted in its course. Chauvenau modified this somewhat by showing that there must be something to produce a vibration in the blood current, a *veine fluide*, as it passed into a larger from a smaller tube, and in anæmia the blood was supposed to be more easily thrown into vibrations from its thin and watery nature. De la Horpe made a number of experiments, which went to show that the murmur was produced by the mere altered condition of the blood. This theory has been clearly disproved by a number of careful workers.

Balfour modifies Chauvenau's theory somewhat, holding that in anæmia there was more friction between the blood current and the walls of the vessels.

It is generally loosely stated in the the text books that these hæmic murmurs are produced by an altered blood. As was just stated, this theory has been completely subverted by many experimentors, who show that although a thin blood, deficient in corpuscular elements, may be a factor, still it cannot of itself originate a murmur.

Chauvenau's theory, though not entirely satisfactory, even after its many modifications, is far preferable to the one just mentioned. It is based upon the following facts: In anæmia the total amount of blood is reduced, and the vessels, by their elasticity, accommodate themselves to the lessened quantity of fluid, and contracting diminish the lumen; at the root of the neck, however, the large arteries do not admit of a like contraction, and the veins are held tight down by the deep cervical fasciæ which prevents their restriction. Thus there is produced the necessary conditions, namely, the passage of blood from a smaller to a larger tube. There are several objections to this theory: In the first place, an anæmic murmur is often heard in cases of sudden loss of blood where we know the vessels are rapidly replenished by serum, and the total quantity of fluid remains unchanged. Also, it is extremely improbable that in cases of moderate anæmia, where the murmur is often distinctly heard, that the blood-vessels and cavities of the heart itself are appreciably diminished in size. The hæmic murmur is heard, as has been noted, not only in cases where the corpuscular equilibrium is disturbed, but in many wasting and debilitating diseases. In other words it is perceived in cases where there is general and decided relaxation of all the tissues. In the largest veins there is quite an appreciable amount of longitudinal muscular fibres, and in the large arteries also, though in these latter the elastic tissue predominates.

Now take a case where the general muscular system is in a condition of atony, the muscles voluntary and involuntary relaxed and flabby. The patients whole condition shows the loss of tone, the inaptitude for any sort of exertion, the rapidly tireing muscles, the flabby tongue. The involuntary visceral muscles feel this and are not able properly to perform their several functions. We have atonic dyspepsia, imperfect intestinal movements, often prolapse of the rectum. The muscular tissue of the veins and arteries must par-

take of this general want of tone, must be relaxed and consequently produce an uneven and more or less corrugated surface, while it is true that this muscular element is not very highly developed and scanty, it is equally true that there would be required the relaxation of only a few fibers to produce a murmur consistently with either the friction or the vibration theory. In accord with this the phenomona are easily explained; in the cavities we have a systolic murmur produced by the obstruction offered by the relaxed endothelum; in the veins the continuous current produces a continuous obstructive murmur. In the recumbent posture the pressure is reduced and consequently the intensity of the murmur is diminished. This theory would also satisfactorily account for the irregularity of the murmur; it is generally stated to be better heard in the right side, though this is not by any means always the case; also the murmur will be found to vary from day to day, this is especially true when it is beginning to disappear under treatment, sometimes being almost or quite absent and again reappearing. This inconstancy could hardly be possible, were the cause an altered blood, which for a certain time remains constant or nearly so. Then too the artificial production of the murmur by slight pressure with the stethoscope, simply causes an obstruction and consequently a murmur. As to the murmur heard at the cardiac orifices and nearly always simultaneously with the vascular murmurs, clearly the theory of a watery state of the blood cannot obtain here for the same reasons stated above, and no lesion has ever been found.

Guttman and others have held that the murmur is caused by a lack of tension or rather unequal tension of the valvular segments, generally due to slight fatty metamorphosis of the papillary muscles, although no such condition has ever been verified.

It has been suggested that basic murmurs were caused by the pressure of the heart itself upon the pulmonary artery made possible by anomalous or pathological retraction of the edge of the lung.

Balfour and others claim that the murmur is heard not at the valves at all, but in the auricles.

No lesion or incompetency having been ever discovered at the orifices, the murmur being heard nearly always at the base and in conjunction with the vascular murmurs, heard always with the systole, having the same characteristics as the arterial hæmic murmur, is it not fair to suppose that these sounds have their origin not at the orifices at all, but in the aorta or pulmonary artery.

Then the return of the patient to health, whether it be from some acute disease or an alteration in the corpuscular elements of the blood, brings with it a tonic condition of the whole muscular system, and a disappearance of the murmur.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JAN. 22, 1886.

(*Concluded from last issue.*)

Dr. George J. Preston then read a paper on

HÆMIC MURMURS.*

DISCUSSION.

Dr. I. E. Atkinson was pleased to hear this paper; it was very interesting to him as he has an opportunity of seeing many of these cases.

In profound chronic anæmias from whatever cause regurgitant murmurs are almost sure to occur and may be heard at almost any or all the cardiac orifices. The necessarily atonic condition of the heart muscles from mal-nutrition permits the dilatation of the orifices and thus gives rise to the insufficiency of the valves to close them and prevent the back flow.

In acute anæmias the murmurs that may be heard are, as a rule, systolic.

*See page 339.

He hardly agrees with Dr. Preston in calling the murmurs heard in chronic anæmias, hæmic, but rather looks upon them, as he said before, as being due to a relaxed condition of the heart. He had recently seen a young lady who had fainted and in whom a heart murmur appeared and disappeared within a very short time. He thinks it was due to a sudden dilatation of the heart. He thinks murmurs arising as a result of anæmia are pronounced for their diffused character. You can detect a decrease in this characteristic, proportionate to the improvement in the general condition. We should be very guarded in diagnosing a valvular lesion from the murmur alone.

He wished to call attention to a presystolic murmur, described by Flint, existing in conjunction with aortic regurgitation, the murmur is claimed to be due to the flapping of the valves when unequal pressure of blood occurs on both sides, that is when blowing from the auricle and when regurgitating from the aorta.

BALTIMORE GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY.

REGULAR MEETING HELD FEB. 9, 1886.

The President, GEORGE W. MILTENBERGER, M. D., in the chair. WM. E. MOSELY, M. D., Secretary.

Dr. A. F. Erich read the following paper.

DIAGNOSIS OF FIBRO-CYSTIC TUMOR OF THE UTERUS. LAPAROTOMY AND SUPRA-VAGINAL AMPUTATION OF THE UTERUS.*

DISCUSSION.

Dr. W. P. Chunn asked Dr. Erich the character of the fluid withdrawn by aspiration; did it coagulate on exposure to air. He had always considered that if the fluid coagulated, it was a proof of fibro-cystic tumor, as the rule, to which he knew there were exceptions, was, that fibro-cystic fluid was blood minus its corpuscles and would coagulate when exposed to the air.

Dr. Erich answered that, as the amount of fluid obtained was very small and, as it was wanted for microscopical examination, he did not test its coagulability. As he said in his paper, the microscopical examination threw no special light on the diagnosis.

Dr. T. A. Ashby said that Dr. Erich had stated that he had used thorough antiseptic precautions in this operation. He would like to ask the doctor what antiseptic method he had employed.

Dr. Erich replied that the ceiling, walls and floor of the patient's room were swept and washed and then sprayed with a carbolic acid solution. Only those required as assistants were permitted to be present and all were dressed in freshly washed linen, their finger nails cut and hands thoroughly cleansed. Carbolic acid solution was used for instruments and a 1 to 2000 solution of bi-chloride of mercury for sponges, etc. The dressings for abdominal wound and vagina were described in the paper.

Dr. T. A. Ashby said that the object of his question was to elicit some discussion on the use of antiseptics in abdominal surgery. As is well known, opinions differ very widely among European abdominal surgeons in respect to the use of antiseptic agents within the abdominal cavity. While thorough Listerian principles, including the use of the spray, are enjoined by a surgeon of Mr. Thornton's acknowledged ability and experience, all antiseptic agents are discarded by so successful an operator as Mr. Lawson Tait. One fact is clear amid all the confusion respecting the details of antisepticism, and that is the great value of absolute cleanliness, which is the essence of Mr. Lister's teachings. Modern statistics show the great value of these principles in abdominal surgery and he would be indeed a bold operator who failed to apply these principles, modified only as to details.

Dr. Chunn questioned the advisability of introducing a drainage tube in those cases where there were no adhesions, and consequently no blood or fluid

*See page 337

of any kind left in the peritoneal cavity. This opinion he based upon the teachings of Mr. Keith. He considered that if any fluid did collect in Douglas's space, it could be easily detected and gotten rid of. He was of the opinion that a woman of forty with a growth like that shown could be tided over until after the menopause, which could not have been many years distant in the case reported.

Dr. H. P. C. Wilson questioned the report that some distinguished operators entirely ignored antiseptics. Some, he was aware, did not use the spray, but he was under the impression that they were careful to see that all sponges, instruments and appliances that had been used in one operation, were rendered thoroughly antiseptic before being used in another. Several acids, bi-chloride of mercury and other agents were antiseptic and if any of them were used to guard against septicæmia those employing them could not be said to be opposed to antiseptics in abdominal surgery. As far as he was personally concerned, he still had great faith in antiseptics, especially in hospital practice, and he favored the use of the spray in such cases, having it stopped only just before beginning the operation. He never could understand why we should be so careful in disinfecting sponges and not use as great precaution to render antiseptic the air around hospital operations. In one case he did a laparotomy upon a patient at the same time that there was a case of erysipelas in the next room and the result was uninterrupted recovery. At another time he removed an ovarian tumor from a woman who occupied the same room and bedstead that had been vacated only ten days before by a patient having a sloughing fibroid, from which the staunch was so great that it was nauseating to enter her room and rendered the air of the whole floor offensive. In this room the carbolic spray was used liberally for several hours before the operation, and especially under, around and in the bed. In some cases he washes out the abdominal cavity with bi-chloride solution before closing the incision.

Dr. T. A. Ashby said he had not had any opportunity of seeing Mr. Tait operate and so was not personally familiar with his methods, but Mr. Tait had published the fact that he had no faith in the so called antiseptic agents and believed they did more harm than good. At one time he (Mr. Tait), had practiced the Listerian ideas in all their details, but they disappointed him and he gave them up. He took water from the tap and put it into the the basin for the sponges, over the instruments and into the abdomen, but he practiced the most rigid enforcement of cleanliness. Dr. Ashby had recently, through the courtesy of Dr. Chambers, the resident physician, had an opportunity to examine Dr. T. G. Thomas' private hospital from cellar to garret. Every idea that prevails in its construction and management has reference to purity of air, scrupulous cleanliness and absolute comfort. But, with every modern convenience for ventilating, heating and lighting, Dr. Thomas still employed a thorough system of antisepsis and in every detail of his operative work reference is had to disinfection and absolute cleanliness. Dr. Ashby expressed the opinion that, in our country at least, omission of antiseptic precautions in abdominal surgery would mean an increased death rate and that no surgeon could, in justice to his patient or his own reputation, afford to hazard an operation within the abdominal cavity without using those methods of antisepticism that are expressed in the Listerian idea.

Dr. Ashby asked permission to relate the following case which he considered of interest in connection with the case reported by Dr. Erich. The patient was a negro woman, age 31, and had been married between 9 and 10 years. Her youngest child was about 8 years old. For four or five years past she has lost considerable blood during menstruation and has noticed an enlargement of the abdomen, but attributed the latter to taking on flesh. For several months past menstruation has been very profuse, generally lasting about eight days. During the intermenstrual period she has a discharge

from the vagina of a clear watery fluid, and varying in amount from a teacupful to a pint in twenty-four hours. The discharge of fluid is spasmodic in character, deluging her clothing. Her general health is at about par. Physical examination reveals a globular tumor about the size of a uterus at the fifth month of pregnancy. The tumor has thick, dense walls and is largest at it upper part. The cervix uteri is normal in size and feel. The sound enters the uterus 5½ inches, is grasped tightly by the lower segment, but rotates freely in the cavity near the fundus. Dr. Ashby's diagnosis is, a fibroid tumor of the uterus undergoing cystic degeneration. The indications for treatment are palliative, as in the present condition of the patient no operative procedure would be justifible. The case is of interest from the fact that the woman's health remains so good, and that the cyst should have opened into the uterine cavity and allowed its contents to discharge as described.

Dr. W. E. Moseley thought one great source of misunderstanding in regard to antisepticism came from the inclination people showed, to limit disinfectants to the so-called antiseptic solutions and powders. Those surgeons who decry most loudly the use of antiseptic precautions are very careful to expose their sponges, etc., to a high degree of heat before using and thereby make use of the most powerful means of rendering them aseptic. Live or free, dry steam is found to be the most effective agent in disinfecting on a large scale. The numerous antiseptic preparations have their places, but many of them are almost or quite useless, unless used in very concentrated form, and others are posionous or irritating and caution must be exercised in their application.

Dr. Erich said that in institutions having arrangements for disinfection by heat, much could be done by that means, but in our own hospitals he thought it necessarry to have recourse to antiseptic fluids.

If any question arose as to the diagnosis of the case reported he would refer those present to Billroth's work, mentioned in his paper, and ask a comparison of the specimen with the description found there. He thought many cases were diagnosticated fibro-cysts which were not really such, as for instance, one operated upon by himself, which proved to be an old abscess of a broad ligament. The rule laid down by authorities is, that fibro-cysts contains either blood, serum or lymph and that the diagnostic value of coagulability of the fluid contents depended entirely upon the character of cystic degeneration. In the seventy cases of fibro-cystic tumors collected by O. Hear only eleven contained fluid coagulating spontaneously.

Regarding the question, whether the removal of a growth, the size of that shown, was a justifiable procedure or not, he thought the social position of the patient had much to do. He considered that a rich woman would have been able to endure the growth for a considerable time, even until the menopause, as she could place herself among the very best surroundings and have proper care; but, in the case in hand, the woman was poor and obliged to earn her own living, which the growth prevented her from doing. He had represented fully to his patient all the dangers attending the operation and she had insisted upon undergoing it. In such cases he thought we had no right to refuse to operate.

He considered the dectection of a small amount of fluid in Douglas's *cul-de-sac*, unless encapsulated, an impossibility, as free fluid would recede upon the slightest pressure from without. The peculiar form of drainage he had adopted was that recommended by Martin, of Berlin, and had been used by him in several cases with the best results.

Dr. P. C. Williams asked for an explanation of the fact that, in a woman dying of asthenia, there should be a temperature of 96° F. immediately after the operation and that it should rise each day until it reached 104.8° F., on the day of her death. Would not such a range of temperature indicate some inflammatory or septic complication?

Dr. Erich replied that he considered

it an advantage to have a slight rise of temperature after an operation as he thought it indicated a greater amount of vitality in the patient than if it had a tendency to remain sub-normal; that with the closure of the peritoneal edges by exudation of lymph, there must be some local peritonitis.

Drs. T. A. Ashby and *H. P. C. Wilson* emphasized the importance of taking the patient's social position into account in considering the advisability of any operative procedure, and agreed with Dr. Erich in his conclusions.

Dr. Robert T. Wilson exhibited some surgical needles, the invention of David Genese, D.D.S., of this city. Dr. Genese calls his needles "Iridirized Platina Needles." They are made with platinized gold head, hardened under hydraulic pressure. Needles can be made by this process of any shape or size and they are said to be indestructible under the pressure of the forceps or the action of acids, but can be bent to any desirable curve.

Dr. Moseley thought that, judging from the needles shown, they would be useless in any operation where much force would be required for their introduction. Strong steel needles will often bend and sometimes break in the hands of skillful operators, and in such cases a needle which can be bent as easily as the samples would be of absolutely no value. They might be of use in a limited class of cases where their introduction would require but little force.

Dr. Erich said that the danger of the steel needle breaking at the eye could be obviated by heating it at that end and allowing it to cool slowly. This would not interfere much with the temper of the needle at its point.

In his operations for lacerated cervix he uses a tourniquet and supposes he is a marked exception to the rule, in so doing. The instrument he uses is his own device, is like a light écraseur with cat-gut for a chain. His special reason for using it, aside from preventing hæmorrhage, is that it so benumbs the cervix that he does not need to use any other means of producing anæsthesia except in the case of very nervous women when he has recourse to ether or chloroform. The use of this instrument demonstrated to him the fact that, after the parts had been ligated for some time they would shrink, allowing the bleeding to return and requiring tightening of the tourniquet and had thus taught him not to depend upon a ligature in supra-vaginal amputation of the uterus.

Dr. B. B. Browne said that in many cases of deep laceration of the cervix, extending up to and beyond the vaginal junction, he thought it would be difficult if not impracticable, to apply the tourniquet above the seat of laceration. He asked Dr. Erich how, in such cases, he prevented cutting the ligature of the tourniquet while removing the cicatricial tissue from the angles.

Dr. Ashby stated that he continued to employ the tourniquet in a certain number of cases. He had found it useful in those cases where the cervix uteri was much elongated and when there was hyperplasia and conjestion of the cervical flaps. He could verify the assertion made by Dr. Erich as to the necessity of constantly tightening the loop of the tourniquet in consequence of a shrinkage of the tissues. He had never employed cat-gut as a loop but used very flexible wire.

Dr. H. P. C. Wilson could not see how, in those cases in which the laceration extended up to the vaginal junction, it would be possible to apply the tourniquet so as to clear out the angles without cutting the cat-gut cord. He thought that in certain special cases the instrument might be of use.

Dr. Erich replied, that when the uterus was easily movable, by drawing the cervix well down, the tourniquet could be applied above the angles of the deep laceration, even above the internal os. That the only cases in which he had difficulty, were those in which there was a very short and conical cervix, or the uterus was fixed, so that could not be drawn down far enough.

The New York Polyclinic has had a most encouraging success. Since the opening of the school in November, 1882, 702 physicians have attended its courses.

TRANSACTIONS OF THE GYNÆCOLOGICAL SOCIETY OF CHICAGO.

REGULAR MEETING, HELD DECEMBER 18TH, 1885.

(*Continued from last issue.*)

II. *Dr. Henry T. Byford* read a paper, entitled

REPORT OF A CASE OF PELVIC ABSCESS WITH REMARKS UPON THE TREATMENT.

Mrs. T., aged 25 years; married five years; German descent; of nervous temperament; small and slight in figure, but in good general health, consulted me, during the fall of the year 1884, for sterility and dysmenorrhœa. She had never menstruated without pain, but had otherwise enjoyed good health. An examination revealed a small uterus and cervix, with acute anteflexion and constant apposition of the anterior and posterior uterine walls. Slippery elm tents, used about once in eight days, alternated with glycerine tampons, had for their effect a gradual relief of the dysmenorrhœa.

About the middle of the following February, I was called to her house to treat her for a severe attack of pelvic cellulitis, contracted a week before while returning home from a dance. The whole pelvic connective-tissue seemed involved, and large tender lumps could be felt externally in the left iliac region.

Six weeks from the beginning of the attack, an abscess opened into the anterior wall of the rectum, about two inches from the external anal orifice. On account of the extreme debility of the patient, her horror of operative procedures, and the absence of any well-marked fluctuation, all surgical interference with the suppurative process had been out of the question.

Palliative treatment was instituted and continued without effect until the sixth of June. In the meantime the pulse remained in the neighborhood of 120° F., and the temperature fluctuated between 99° F. and 102°.; attacks of acute suffering and septicæmic diarrhœa required opiates for their relief; the bacillus tuberculosis was discovered in the pus; yellow pigmentary deposits covered her face, and emaciation became extreme, her weight ranging between eighty-two and eighty-three and one-half pounds. Her courage began to fail, and finally after the concurrent recommendation of the consultants, Drs. Wm. H. Byford, J. E. Owens, George M. Chamberlin and Martin Matter, she consented to an operation.

Accordingly, on the 6th of June, Dr. Wm. H. Byford operated according to his usual method in such cases. After etherization, he forcibly dilated the sphincter of the anus, tore open the fistulous track with the finger, and then enlarged the abscess in the same manner, in the direction of the lowest part of the cavity, until it readily admitted two fingers. I then made a digital examination, and found the abscess to extend across the pelvis, behind the uterus and broad ligaments, above the level of the fundus uteri on the left side, and to be filled with bands and projecting masses of granulation-tissue of about the consistency of freshly coagulated blood. Previous treatment, except to diminish and control the septicæmia, had evidently been a complete failure. All of this medullary tissue was then scooped out with the finger and the cavity thoroughly cleansed with a two and a half per cent. solution of carbolic acid.

The highest temperature after the operation was 99° F., on the day following. Perfect drainage had been secured, for at the time of each dressing no pus was found inside of the abscess.

The cavity of the abscess was treated by irrigation with antiseptic solutions, insufflation with iodoform and the introduction of cupric sulphate.

Early in September she was attacked with the then prevalent epidemic, dysentery, and died on the 23rd instant.

At the post-mortem examination made about thirty hours after death, I was somewhat hampered on account of a promise, exacted by the husband, that no organ should be taken out of the body,

and by the fact that I had but thirty minutes for work before train time. The body had again become extremely emaciated. Abdomen was flat. An incision was made from a little above the umbilicus to the pubic bone. The pelvis was filled posteriorly with a solid mass of plastic tissue, which had drawn the uterus backwards to within about half an inch of the sacrum, so as to put the anterior vaginal wall upon the stretch, and had buried the uterus and other pelvic organs in its substance. Both round ligaments were seen issuing from this mass. It was necessary to cut down about half an inch before reaching the depressed uterus, and to tear through solid tissue behind it to arrive at the rectum below. The finger broke through into the rectum, behind the dimpled cicatrix that marked the site of the former outlet of the abscess. The left broad ligament was then felt to be represented by, or inclosed in, a tough band half an inch thick antero-posteriorly, extending from the uterus to the left side of the pelvis. The left ovary could not be found. A small flat piece of what seemed to be ovarian tissue was found adherent to the bladder on the right side. The right broad ligament was apparently disorganized and inseparable from the plastic deposit. The rectum was held inflated at the point where it issued from the pelvis, was dark-colored and injected on its external surface, and blackish and softened on the internal. Neither the appearance nor the odor of an abscess could anywhere be discovered.

There seem to have been two hinges, as it were, upon which the treatment of this abscess turned: first, the operation per rectum: second, the cauterization by sulphate of copper. Both secured a large opening at the lowest portion of the pyogenic cavity, and brought away the unhealthy granulation-tissue. Had the patient consented to have the unobstructed outflow of the pus maintained by one or two subsequent dilatations, similar to the first one, the cure would undoubtedly have been more rapid. As it was, the contracting sphincter and abcess outlet rendered the drainage and irrigation imperfect. Progress toward recovery was, however, again inaugurated upon the melting away by the sulphate of copper of the newly and imperfectly formed cicatrical tissue, reproducing the opening made at the time of the operation and by the destruction of the degenerative deposits and cauterization of the chronic pyogenic surface. The only kind of treatment preferable to this free drainage and clearing out method is the strictly antiseptic, which, after the pus has once found a way into the rectum, can only be accomplished by first closing this septic inlet.

The treatment by a counter opening in the vagina is much less preferable, because a recto-vaginal fistula, difficult of cure, and liable, like anal fistula, to inoculate the system with tuberculosis would be left.

The treatment by abdominal incision cannot for a moment be entertained for at least two reasons:

1st. It is necessarily followed by a recto-abdominal fistula of great length, which is incapable of being promptly cured, and is apt to become an unfailing source of systemic infection. Those patients already operated upon, as far as reported, have usually either died shortly, or within a year or two, imperfectly cured. They would have, on an average, lived about as long without the operation. In fact, it is not impossible that one such, whom I had, previous to the operation, an opportunity of watching for a short time, would finally have recovered through the process of nature. To operate as does Lawson Tait, before the abscess has discharged, and then treat it antiseptically through its single opening, is an entirely different matter.

2d. The danger of an abdominal incision should never be incurred without a prospect of compensation in the way of bettering the patient's chances of recovery. Neither theory nor practice as yet prove such compensation to be attainable.

In some cases one dilatation per rectum, without after-treatment, has sufficed for a cure: in other cases two or more, with subsequent antiseptic irrigations, have become necessary. But as a gen-

eral rule it may be said that, unless instituted too late, the procedure is safe and the recovery sure.

DISCUSSION.

Dr. Christian Fenger made some remarks on laparotomy as compared with other operations, of which the following is a brief abstract:

When a peri-uterine abscess points somewhere in the vagina around the lower part of the uterus, no surgeon would, of course, think of doing anything but opening the abscess, inserting a drainage tube, and by washing out, endeavoring to effect the closure of the cavity. But in some cases the opening into the vagina is just as ineffective as a spontaneous opening into the rectum. In obstinate cases of this kind laparotomy, at a later period, will have to be performed.

There is, however, no doubt that secondary invasion of septic poison, when the abscess is opened from the vagina, is much more difficult to prevent than invasion into the abscess from the abdominal opening. It is only in this way that we can account for the difference in the course of the after-treatment of peri-uterine abscesses opened through the vagina and through the abdominal cavity; a difference that Lawson Tait rightly calls attention to as being decidedly in favor of the abdominal operation. Here the abscess closes more quickly, and the course of the after treatment is much less febrile than in the vaginal operation.

Sometimes a peri-uterine abscess will point into the rectum, sufficiently low down to permit of an opening here. It does not seem probable that the access from the rectum will be very promising, as effective drainage is next to impossible; but the cases of cure by spontaneous opening into the rectum evidently make an operation here permissible, and perhaps advisable, but only as a trial. If the abscess does not retract within a reasonable time, other measures must be resorted to.

It is needless to state that if a parametritic abscess points anywhere along the iliac fossa, it should be opened and drained from this point; but this does not belong to my subject of to-night, as I desire to call attention only to strictly circum-uterine abscesses, which can only be reached from the vagina or from the supra-pubic region.

When a circum-uterine abscess does not point downward, and, in fact, does not point anywhere, it is then the surgeon's task to find the safest way into the abscess through a smaller or larger amount of surrounding tissues.

We shall first consider the vaginal operation:

When so eminent an authority as Schröder, of Berlin, advocates this method of reaching a high peri-uterine abscess there must be cases in which this operation is advisable. From a general point of view an extra-peritoneal outlet of the abscess through the vagina would seem to be safer than laparotomy, upon the same grounds as a vaginal hysterectomy is safer than Freund's abdominal hysterectomy, and Schröder's successful operation, already mentioned, vouches for the method.

At the same time, I firmly agree with Lawson Tait, that there are some grave objections to the vaginal operation. In the first place, a high-seated peri-uterine abscess is difficult to reach. It is difficult to work with safety two or three inches above the introitus of the vagina, in tissues that are immovable, and where the parts cannot be drawn down toward the operator. These difficulties are, of course, of less importance in the master hands of an operator like Schröder, but increase in significance for less experienced surgeons.

But the operation through the vagina is more or less an operation in the dark. We may be dissecting up along the posterior surface of the neck of the uterus, and may open into recesses of the peritoneal cavity between the abscess and the uterus. Further, it might be easy in this place to open into the rectum.

Another danger, especially in abscesses between the two layers of the lateral ligament, might easily arise from the rupture of the large uterine vessels run-

ning in the wall of the sac. It would be exceeding difficult, and I should say next to impossible, under such circumstances, to secure and ligate these vessels, the point of ligation being so high up, the working space so small, and the tissues so immovable.

All those objections and dangers we do not encounter in laparotomy. We can see distinctly, and recognize with our own eyes, every particle of tissue we have to divide; the large uterine vessels, if divided, can easily be taken up and ligated. There is no risk of having any communication between the abscess and the peritoneal cavity, which we cannot either close up or drain.

If the laparotomy lasts longer, and gives more technical work to the surgeon, it seems to me that these objections are fully balanced by the advantage of not being obliged to operate in the dark, of not having to battle with enemies that we cannot see, and consequently cannot guard against.

But these are not the only advantages of laparotomy, as compared with the vaginal operation. The free access to the whole interior of the abscess cavity has also to be taken into account. By laparotomy, the abscess is laid open to about the same extent as a tubercular peri-articular abscess. We can examine the whole interior of such a cavity, and scrape off, or remove by other means, whatever objectional material we may find, cheesy matter, tuberculous tissue, fungoid granulations—since we can see clearly every place where the instrument is applied, without any danger of going through the abscess wall into any surrounding cavity or organ.

It is more than possible that this free access to the abscess wall has something to do with the speedy recovery subquent to laparotomy, as compared with the vaginal operation.*

But, of course, there will always be connected with laparotomy the inherited dread of opening that ominous peritoneal cavity. Modern surgery, however, is making steady progress in diminishing these dangers. Thus, the dread, as well as the safety of the patient, will, to a great extent, rest in, or depend upon, the care and skill of the operator.

Dr. W. H. Byford: I do not wish to comment upon the contents of this paper further than to express myself in reference to the mode of operating adopted in consultation with the gentlemen mentioned. A large number of pelvic abscesses can be managed through the rectum with more facility and safety, than any other medium of approach to the deep-seated portions of the pelvic cavity. I do not know whether there are any cases wholly situated in the pelvic cavity, but that can be reached, opened and evacuated through the rectum. It may not always be the most eligible direction to approach collections of pus. In instances in which the pus is making its way towards the vagina, and fluctuation can be felt through the vaginal walls, it ought to be evacuated through that canal; but when the point of discharge is not thus indicated the exploration is most easily made through the rectum; and all chronic cases that have already commenced to discharge into the rectum can and ought to be treated from the cavity of that viscus. I would make no exception, however high the opening might be, so it was within the pelvic cavity. By proper preparation the whole length of the rectum can be reached from the sphincter to the promontory of the sacrum, and from any part of it the pus evacuated; the pyogenic cavity explored and drainage and irrigation safely and securely accomplished.

I believe the dangers of this mode of operating to be incomparably less than by abdominal section; and the other results of the operation—such as drainage and disinfection—more complete.

To effect the objects mentioned, the sphincter should be stretched to laceration; and until there is no tendency to immediate contractions of the anal opening, and till it can be dilated to the full extent of the rectal cavity. Thus thoroughly opened, the whole extent of rectum can be explored with great facility and often by means of dilators can

*Lawson Tait, op. cit.

be seen, and instruments used under the eye of the operator.

If the pus is to be sought after, palpation with the fingers becomes easy and satisfactory; if it is being evacuated, the orifice seen or felt and such treatment as is desired applied. I much prefer stretching and tearing for the purpose of increasing the size of the discharging orifice to the use of cutting instruments. The opening will not so readily close and there will not be so much hæmorrhage.

In effecting the discharge of the pus, we should remember that the reason why the pyogenic cavity is at no time wholly obliterated is because there are irregular loculi or pockets so situated that they do not empty themselves. The opening should therefore be made large; the parts torn by the fingers until this inferior margin of the opening is as far below the main body of the cavity as practicable. With the fingers the interior bands and partitions should be completely broken down and the interior of the cavity rendered as nearly symmetrical as possible. This will enable the whole of the contents of the cavity to escape by means of gravity, and the fluids used in irrigation find their way out without difficulty. In addition to this shaping of the cavity, the large granulations—generally so abundant—should be scraped away by the fingers or by a dull curette, thus freshening up the lining membrane of the pyogenic cavity and converting it from a state of indolent ulceration to one disposed to heal. This process of curetting also produces a change in the capillary circulation that makes nutritive processes more salutary. Often in very indolent cases the sphincter will recover contractile power to such a degree as to require one or more repetitions of the operation. The same thing may be said of the margin of the orifice in the intestines. We will be obliged to enlarge it and treat the cavity as before.

In the case narrated in the paper, the action of the sulphate of copper seemed most useful and contributed the last influence necessary to the cure.

I have said nothing about the more common items of treatment, such as irrigation, disinfection and stimulation. My intention is to show the facility with which, in many instances, these purulent collections can be reached and treated by dilating and distending the rectum and the comparative safety of such proceedings.

Dr. E. C. Dudley: The experience of Dr. Byford and others in the treatment of pelvic abscess by this operation must be considered as proving the great value of the operation in cases in which the abscess can be easily approached and thoroughly drained by dilatation of a sinus between the abscess-cavity and the rectum. It would, however, appear on general principles, that sufficiently free and long-continued drainage would in many cases be almost unattainable and that an abscess-cavity left thus to heal must often be the starting point of sinuses formed by the untrolled burrowing of pus in many directions. The almost inevitable invasion of the abscess-cavity by fecal matter is clearly a serious factor in connection with the history of these cases. The great mortality from pelvic abscess opening spontaneously into the bowel demonstrates the inability of nature to provide for adequate drainage. Whatever question, therefore, we may raise relative to the advanced position of Dr. Wm. H. Byford, who, if practicable, would prefer to open a pelvic abscess through the rectum—even in those cases in which nature has not anticipated him—there can be no question about the propriety of enlarging and rendering more effective an opening already formed. I regret that the essayist has marred a most admirable contribution by the sweeping statement that in all cases in which drainage has been spontaneously established through the rectum Lawson Tait's operation is contra-indicated. Nor can I imagine from what premises he has formed the conclusion that Tait's operation prevents closure of the sinus between the abscess-cavity and the rectum. The question naturally arises whether Tait's operation might not in such cases fulfil a well recognized surgical indication by establishing a free counter-opening for an abscess which otherwise might refuse

to close on account of imperfect drainage and on account of its forming a blind sac for the retention of fecal matter. To a larger number of recognized authorities, who deem an opening into the rectum, whether produced by nature or by art, a grave misfortune, the query would naturally arise whether such an opening ought not to be supplemented by a counter-opening, which would bring the draining and cleansing of the abscess-cavity within the easy and absolute control of the surgeon. Furthermore, in view of the decided mortality which attends the spontaneous opening of pelvic abscesses into the rectum, and in view of the almost uniformly successful results recorded in the statistics of Tait's operation, already published by Mr. Tait and others, and in view of a very generally accepted rule that the operator in opening a pelvic abscess should strive to keep out of the rectum, I don't think a statement that the rectum is to be preferred as the site of the primary operation ought to go on the records of this society unchallenged.

Dr. J. T. Jelks (present by invitation) thought a great mistake was made in waiting too long before operating in cases of chronic pelvic abscess.

Dr. Philip Adolphus thought the paper was beyond the pale of criticism. When the general symptoms indicated a collection of pus, the cavity should be searched for. If a cavity containing serum was found, an operation was contra-indicated. If the cavity contained pus, it should be evacuated.

In closing the discussion, Dr. H. T. Byford objected to the quotation of Lawson Tait's statistical triumphs in this connection. In the last edition of Tait's *Diseases of the Ovaries*, abdominal section is reccommended for those pelvic abscesses only that cannot be successfully evacuated from below. They are generally such as are situated high up, and do not point early in the vagina or rectum, or they are suppurating hæmatoceles.

The statement that the recto-abdominal fistula, left after abdominal section for a pelvic abscess that has already discharged into the rectum, would heal readily, like an artificial anus, is not borne out by facts. Fistulæ connecting the rectum with the external air have seldom healed, when left to themselves, before a long a period of time had elapsed. Operative measures cannot (in these cases) be resorted to on account of the length, situation and relations of the fistulous track.

Correspondence.

THE AXIS-TRACTION FORCEPS.

BALTIMORE, February 22, 1886.

Editor of Maryland Medical Journal.

DEAR SIR:—In connection with the above subject *persistent* and *repeated* attacks have of late been made against me by Professor W. W. Jaggard, of Chicago.

These attacks have been severally answered by me in the *Journal of the American Medical Association*, September 26, October 17, and 31, 1885; and in the *Therapeutic Gazette*, February 15, 1886.

I regret that the reiteration of these attacks by Professor Jaggard before the *Gynæcological Society* of Chicago, assembled December 18th, 1885, recently published in the transactions of this meeting, force me to resume a subject which must be of little scientific interest to the general medical reader.

I am well assured that those of the profession who know me, have not had their good opinion of me in the least shaken by these attacks, that to the most casual and disinterested reader *must seem to have some more subtle motive than Truth and Science.* Actuated by a purely honest and scientific motive I placed before the profession "An Obstetric Forceps" (*Obstetrical Journal*, September, 1885,) which was identical with an instrument previously designed by Dr. Felsenreich, of Vienna, in one particular, namely, that the traction rods were attached to the blades of the forceps by means of a button-hole joint, for which I have always given Dr. Felsenreich full credit in every verbal and written communication. In this point the instruments are identical and in this alone, as may be seen by consulting the diagrams (*Obstetrical Journal*, September, 1885, and *Journal American Medical Association*, February 6, 1886,) or by reading the discriptions published in the journals above referred to, or by examining the instrument, which will soon be on exhibition at Mr. Charles Willms', of Baltimore.* Now, as to whether "the difference between the modifications of Felsenreich and Neale are not great and certainly not essential," (*Association Journal*, Feb-

*I will mention, that Dr. F. says his "forceps consists of the common forceps of J. Y. Simpson," (*Association Journal*, February 6 1886,) while I adhere to the Alex'r Simpson model as already published (*Association Journal*, October 31, 1885).

ruary 6, 1886,) is a matter not at issue and consequently one that I shall not here discuss. But I must repeat that the statement made by Professor Jaggard, that my "allusion to Dr. Felsenreich's suggestion of the botton-hole joint is, to put the case very mildly, disingenious," (*Transactions Genæcological Society*, Chicago, December 18, 1885,) is "not only *palpably but unqualifiedly and wilfully false!*" (*Therapeutic Gazette*, February 15, 1886.)

The above closes what I have to say upon this subject, for I positively decline to answer any further communications from Professor Jaggard. Respectfully,

L. E. Neale, M.D.,
Baltimore.

BOOKS AND PAMPHLETS RECEIVED.

Fractures and Dislocations. By T. Pickering Pick, F.R.C.S., Surgeon to and Lecturer on Surgery at St. George's Hospital, etc. Illustrated with 93 Engravings. Philadelphia. Lea Brothers & Co. 1886. Pp. 517.

A Manual of Auscultation and Percussion, Embracing the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurism. By Austin Flint, M.D., LL.D., Professor of the Principles and Practice of Medicine and of Clinical Medicine in the Bellevue Hospital Medical College, etc. Fourth Edition Revised and Enlarged. Philadelphia. Lea Brothers & Co. 1885. Pp. 274.

Practical Human Anatomy, a Working Guide for Students of Medicine and a Ready-Reference for Surgeons and Physicians. By Faneuil D. Weisse, M.D., Professor of Practical and Surgical Anatomy, Medical Department of the University of the City of New York. Illustrated by 222 Lettered Plates, Containing 321 Figures. New York. William Wood & Company. 1886. Pp. 432.

The Principles and Practice of Medicine. By the Late Charles Hilton Fagge, M.D., F.R.C.P., Physician to and Lecturer on Pathology at Guy's Hospital, etc. Including A Section on Cutaneous Diseases, by P. H. Pye Smith, M.D., F.R.C.S; Chapters on Cardiac Diseases, by Samuel Wilkes, M.D., F.R.S., and Complete Indexes, by Robert Edward Carrington, M.D. Volume II. Philadelphia. P. Blakiston, Son & Co. 1886. Pp. 780.

Local Anæsthesia in General Medicine and Surgery, Being the Practical Application of the Author's Recent Discoveries. By J. Leonard Corning, M.D. New York. D. Appleton & Company. 1886. Pp. 100.

The Diagnosis and Treatment of Diseases of the Ear. By Owen Pomeroy, M.D., Surgeon to the Manhattan Eye and Ear Hospital, etc. With 100 Illustrations. Second Edition Revised, With Additions. New York. D. Appleton & Company. 1886. Pp. 408.

Puerperal Pyrexia. By Geo. P. Andrews, M.D., of Detroit, Mich. Reprint from the *American Lancet*, Jan. 1886. Pp. 32.

How We Treat Wounds To-Day. A Treatise on the Subject of Antiseptic Surgery Which Can Be Understood by Beginners. By Robert T. Morris, M.D., Late Home Surgeon to Bellevue Hospital, New York, etc. New York and London. G. P. Putman's Sons. 1886. Pp. 161.

Brain Rest, Being a Disquisition on the Curative Properties of Prolonged Sleep. By J. Leonard Corning, M.D., Member of American Neurological Society, etc. Second Edition, Revised and Enlarged, With Additional Illustrations. New York and London. G. P. Putnam's Sons. 1885. Pp. 135.

A Report of Five Cases of Ovariotomy from the Records of the Hospital for Women of Maryland. By C. O'Donovan, Jr., M.D., Assistant Surgeon. Reprinted from The Transactions of the Medical and Chirurgical Faculty of Maryland, 1885. Pp. 15.

Gastro-Enterostomy.—A woman was recently admitted into University College Hospital, suffering from symptoms of pyloric obstruction. As a very mobile tumour could be felt in the situation of the pylorus, an exploratory laparotomy was performed by Mr. Arthur E. Barker. The new growth was found to extend too far along the lesser curvature to permit excision of the whole tumour and pylorus, and a palliative operation was therefore performed. A loop of the jejunum was picked up, and an opening one and a half inches long made in it; an opening of similar dimensions was then made in the stomach, and the two stitched together. In this way, a short cut was provided by which the chyme could pass from the stomach into the jejunum without traversing the diseased structures. The patient bore the operation well, and was able to take food by the mouth five days after the operation. Fourteen days after the operation she was completely convalescent, and expressed herself as greatly relieved.—*Br. Med. Jl.* Jan. 23, 1886.

Ichthyol.—Dr. Lorentz recommends ichthyol in a variety of cases. In a 30 per cent. solution, it relieves the severe itching of senile prurigo; for pruritus, a weaker solution is used, namely, 10 per cent. As an application to slowly granulating burns and ulcer, he has had excellent results; and internally, in doses of four tablespoonfuls of a 1 per cent. solution in the day, he has relieved the symptoms—vomiting, etc.—of catarrh of the stomach.—*Br. Med. Jl.*

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BALTIMORE, FEBRUARY 27, 1886.

Editorial.

BACTERIOTHERAPY.—When the bacteria craze first commenced the thought suggested itself to us whether any practical results would be likely to ensue from such reseaches, and we feel constrained to conclude that so far our therapeutic progress has not been advanced one iota by these investigations.

Granting, for the sake of the illustration, that phthisis is caused by the bacillus tuberculosis; does consumption of the lungs not claim its victims and fill our graveyards just as frequently as it did before the announcement of Koch's decovery? Supposing that the comma-bacillus is the etiological factor of cholera; have the ravages of this terrible disease been lessened in the least,since this supposed fact was stated?

We ask these questions, because, while we do not wish to detract from the value of scientific medicine, yet we do fail to see any benefit that mankind is to derive from science that has not its practical application, and we utterly fail to see that there has as yet been any practical application of the science of bacteriology. As a rule the mind of man runs in practical groves, but it is singular to note how sometimes the universal mind of the world, the attention of those who are ordinarily extremely conservative and practical, will be taken by storm, as it were, will completely surrender to views that are, to say the least, very visionary.

But recently, we heard a very intelligent person remark: "Is it not a great thing for France, that the Newark children have come home cured?" "Cured of what?" we asked, "of hydrophobia;" "but we never heard that they had hydrophobia," "no, but they would have had it, had it not been for Pasteur's inoculations." "Ah! indeed," we replied, "your prophetic wisdom is truly great." This person was not at all ignorant, but his usually conservative mind had been completely unbalanced in this particular line by the published reports of Pasteur's experiments.

As Buffon and Bonnet captivated and held in bondage the world of the eighteenth, by their beautiful theories, which they *seemed* to demonstrate as facts, so now do Koch and Pasteur hold the nineteenth century, with theories equally beautiful, but also, we fear, equally devoid of practical results.

It is a fact that no great progress in therapeutics has ever been made by design, so to speak; our whole therapeutic science is an aggregation of clinical surprises; a man has observed, without previous theory, that a certain article produces a certain effect, and thus, little by little, case by case have we built up our therapeutics. No man ever made a great discovery in therapeutics from a pre-conceived theory, any more than in any other science. Of course, attempts innumerable have been made to secure a system of therapeutics based on the bacillus doctrine of disease, but such attempts have been, universally, failures, and we must say again that the bacillus discoveries have been absolutely barren of results so far as therapeutic or curative measures are concerned.

They have, however, served a good purpose in another way. The science of preventive medicine has been greatly advanced by these researches, for they have quite clearly demonstrated to us the agents that we may profitably employ to render impotent the cause of disease. If bacteriologists had done no more than demonstrate to us the great germicidal power of corrosive sublimate, their names would well merit inscription high up on the roll of fame, but they

have done more, they have demonstrated more forcibly than we ever before realized that the majority of the diseases most dreaded by man are absolutely preventible. For this let us be truly thankful, for it is a wonderful blessing. Let us realize that while we can hope for but little, in a curative sense from bacteriology, we may expect wonders in prophylaxis.

Miscellany.

The Treatment of Keloid.—An interesting discussion recently took place, on the subject of keloid, in the Surgical Society of Paris, following the presentation of a case by Dr. Monod. The majority of the members who took part: Monod, Ledentu, Reclus, Berger, and Tillaux, opposed the total ablation of the tumor, largely done with the bistoury, because each time that they have practised this operation they have seen relapses follow. Dr. Lefort and Lucas championed the operation, believing that it should be done when the tumor is pediculated, voluminous, and when it greatly annoys the patient. Dr. Reclus cited a case in which he had obtained great amelioration by local compression with mecurial plaster (*emplâtre de Vigo*), salt baths, and cod-liver oil in large doses internally. Dr. Ledentu and Dr. Berger also spoke of *crossed* linear scarifications carried out according to the method of Dr. E. Vidal. So far as I am concerned, I am convinced that this last procedure is by far the best, or if you prefer the least objectionable, only you must know how to apply it. Each week parallel linear incisions must be made through the whole thickness of the tumor, and passing beyond its borders, and these must be crossed at right angles by other similar incisions, in such a manner as to form little squares. According to my idea, these incisions should be as close together as possible, say two millimetres. In the intervals between the operations, *emplastrum de Vigo cum mercurio* should be kept constantly applied. I have already treated three keloids after this manner. In the first case, the tumor was very much reduced in size, but did not entirely disappear despite a great number of operations. In the second case, where we had to do with two keloid tumors of the right cheek, consecutive to caustic applications, eight scarifications have been sufficient to cause their disappearance, but I am keeping the patient under observation, expecting a reoccurrence of the disease.

The third case is one of enormous keloid, having a diameter of ten centimetres in all directions, and a thickness of one and a half centimetres, situated a little above the pit of the epigastrium. Here I have already done more than forty scarifications, obtaining a diminution of at least five-sixths of its thickness, but I am far from having produced a complete disappearance of the growth. One of the great advantages of scarification in keloid, an advantage upon which Dr. Vidal has insisted, is that of rendering the keloid indolent when it is causing suffering to the patient, which it not infrequently does.—*Jl. Cul. and Ven. Diseases.*

Calomel as a Diuretic.—The *British Medical Journal* says: The action of calomel in causing diuresis in morbid conditions with dropsy is not generally recognised. In health, indeed, it may be said that the drug has no such action. Dr. Jendrássic has found in cases of cardiac dropsy, that calomel in appropriate doses causes well-marked diuresis, a "sort of diabetes insipidus," by which the results of want of cardiac compensation, dropsy and œdema, are dissipated. The effect comes on within twenty-four hours; one and a half grain of the drug being given three to five times a day. No diarrhœa is usually produced; but, in some cases, it had to be prevented by the administration of laudanum. Salivation and stomatitis were obviated by the prescription of a chlorate of potash gargle from the first. The result in all cases in which treatment was adopted, was beneficial; no unfavorable depressing symptoms being noticed.

Trypsin (Fairchilds') as Solvent for Diptheritic Membrane.—The well-known properties of this principle of the pancreatic juice

give strongest grounds for anticipating success in its application for this important purpose. Trypsin acts quickly and powerfully upon fibrin and fibrinous membrane. It is not dependent upon the inter-action of acid as is the case with Pepsine. It is most active in a slightly alkaline media. It may be applied by spray or brush. In practical use the results have been very encouraging.

Messrs. Fairchild Bros. & Foster wish to respectfully announce, that, owing to the great cost of this product and their inability to more than keep pace with the actual demand, they cannot offer samples. It may be obtained of the principal drug houses in this country and is dispensed in ¼, ½, and 1 oz. bottles with full directions. Correspondence will receive prompt attention.

Turpine as a Therapeutic Agent.—A correspondent writes to the *British Medical Journal:* Turpine is a hydrate of turpentine (C_{10} H_{16} 2 H_2 0), and is more commonly known as turpentine camphor. It is obtained by treating the oil of turpentine with nitric acid and alcohol. It is crystallisable, and has the color and taste of ordinary camphor, but is less pungent, and somewhat less terebinthinate. Dr. R. Lépine, of Lyons, has lately been making a series of experiments with this substance among his hospital patients with what appeared to him very satisfactory results. Speaking roughly, its action resembles that of turpentine, but it is more active, consequently it must be employed in smaller doses. Dissolved in water or alcohol, its taste is by no means disagreable, and it agrees very well with the majority of patients. In doses of from four to twelve grains, turpine increases the bronchial secretion, and, by rendering it more fluid, facilitates its expectoration. In cases of subacute and cronic bronchitis, turpine generally benefits the patient; in fifty cases so treated, all the patients without exception wished the treatment to be continued. If the dose be increased, the bronchial secretion is, on the contrary, diminished, and this action may be of service in bronchorrœa, although further observation as to this is wanting. In moderate doses turpine acts as a diuretic, and is very valuable in certain class of cases where the quantity of urine is below normal; but, of course, it must be administered cautiously, if at all, in Bright's disease. In albuminuria, moderate doses of turpine diminish the quantity of albumen, and the symptoms often improve. In people with healthy kidneys, twenty-grain doses do not cause any untoward circumstances, though the excretion of urine may be curtailed. Its action on the nervous system is the same as that of large doses of the essence of turpentine. Given in large doses (one to three drachms) to dogs, hæmaturia and albuminuria result, the action of the drug appearing to be mainly on the kidneys. The best way to administer the drug is to prescribe the alcohol solution in a syrup or other convenient vehicle. When in larger dose, it is well to combine it with an astringent, to prevent any diarrhœa. The tincture of catechu is very suitable with this end in view. It is, morever, apt to cause nausea in some patients. To sum up, turpine is preferable in the majority of cases to the essence of turpentine; "it is," says Dr. Lépine, "an excellent diuretic, acting on the renal epithelium, and has an useful effect on the bronchial mucous membrane, augmenting or decreasing the secretion according to the dose."

Medical Items.

A Neurological Society has recently been organized in London, with Dr. Hughlings Jackson as President, and Dr. Wilks and Sir James Crichton Browne as Vice-presidents.

The medical profession of the State of Ohio, will present a bill to the State Legislature to establish a medical board of examiners and lincense, and to regulate the practice of medicine in the State.

An Association for the Protection of Scientific Research has been organized in Philadelphia, with Prof. H. C. Wood as President. The object of this Association is the prevention of any new legislation rega rding vivisection.

The *New York Medical Journal* informs us that it expected that the Jefferson Medical College will institute the custom during the present year of having written final examinations.

Dr. Meade C. Kemper, a son of ex-Gov. Jas. A. Kemper, of Virginia, died suddenly in Norfolk, on February 23, with heart disease, at the age of 29 years. He was a physician of considerable prominence and gave promise of a highly successful professional career.

The report of the Internal Revenue Department shows for the year ending last June a decline of nine millions in taxes as compared with the year before, showing a greatly diminished consumption of alcoholic liquors in this country.—*Med. Times.*

M. Jules Guérin the "Father" of the Academy of Medicine, died recently at the age of 85 years. He was noted for his eccentricities and combattive tendencies. He stoutly combatted the modern theories on cholera, as also M. Pasteur's inoculation for hydrophobia.

The *Southern California Practitioner* is the name of a new medical journal which began publication in January, 1886. The first number is a handsome octavo of thirty-six pages, filled with an excellent series of orignal articles and other matter. The journal is edited by Drs. J. P. Widney, Joseph Kurtz, and Walter Lindley. It is located at Los Angelos.

Naphthalin is recommended, by Dovodtchikoff, (*British Medical Journal*) as an invaluable dressing for ulcers. It is inexpensive and easily used; after its application, granulations quickly appear and cicatrisation is rapid; its antiseptic properties serve to remove false membranes and bad odors. It does not irritate ulcers, nor produce any pain, and patients continue their avocations without any difficulty.

Vogel relates the following in his "Diseases of Children:" "I once treated an American lady, who still suckled her son, who was *two and a half years old*, till one morning, when the strongly developed, robust child was called to be nursed, he very kindly replied: 'I thank you, dear mamma, the nursing is too tedious for me.'"—*Gaillard's Med. Jl.*

Dr. Baratier recommends very highly the local use of copaiba in the treatment of various forms of vaginitis. He employs a suppository containing three-fourths of a grain of extract of opium and one and one-fourth drachm each of copaiba and cacao butter. One of these is passed into the vagina every second day and allowed to remain for twelve hours.—*Med. Record.*

A correspondent to the *Medical Record* suggests that physicians should always have their cards engraved with the "M.D." after their name, rather than the previx "Dr." to the name. "The abbreviation 'Dr.' does not distinguish whether a man be a physician, dentist, veterinary, lawyer, or divine, all of whom have the legal sanction, and the first three the sanction of custom, for the use of the term 'Doctor.'"

The Medical Society of the State of Pennsylvania, will hold its thirty-seventh annual session in the city of Williamsport, June 2, 3, and 4. The programme must be distributed at least one month prior to the meeting; therefore those who desire to present papers are requested to forward the title and a brief abstract of the subject-matter at an early day to the Chairman of the Committee of Arrangements, Dr. T. H. Hillsbry, Williamsport.

No voluntary paper is allowed to occupy more than twenty minutes in reading.

The annual reunion and banquet of the Alumni Association of the University of Maryland, School of Medicine, will be held at the Eutaw House, Baltimore, Wednesday, March 17th, 1886, at 8 P. M. The Oration will be delivered by Dr. Chas. H. Ohr, of Cumberland, Md. Members tickets $1.25, can be had from Dr. E. F. Cordell, at Library, N. W. Corner St. Paul and Saratoga Streets, from 12 to 3 P. M.; or from Dr. Herbert Harlan, corresponding secretary, to whom also applications for membership may be made. The annual membership fee is $1.00.

The Association of American Medical Editors will hold its next meeting, in St. Louis, Mo., on Monday evening preceding the opening of the next session of the American Medical Association. It has been suggested that this meeting should be made a purely social affair. Former meetings of this Association have been consumed in reading papers, and in discussions which have not tended to popularize its usefulness. These meetings, to put the case mildly, have been rather tame affairs. The idea suggested of having a social reunion may tend to better results. Medical editors do not differ from the average run of the human family in their social proclivities.

The *Medical and Surgical Reporter* says: A curious suit has been brought in Illinois against the Chicago, St. Louis and Pittsburgh Railway, and the Pullman Palace Car Company, to recover $50,000. It is brought by George Brown, an attorney, of Decatur, Ill., whose wife died in May last, and whose remains were sent to Zanesville, Ohio, for interment. A party of five, besides Mr. Brown, went with the body, but by some mistake the body was taken from the train at Indianapolis while the passengers went through to Columbus, Ohio. The body remained at Indianapolis twelve hours, and when it finally arrived at Zanesville it was decomposed. The time of burial had to be changed, and the friends were unable to look at the body. For these reasons the suit to recover damages was brought. The railroad in its answer denies any negligence, and claims that it did all that could be required of it.

Clinical Lectures.

RESECTION OF TWO RIBS—VEGETATIONS OF THE URETHRA—POTT'S DISEASE—CONGENITAL VALGUS—EPULIS—GOITRE—SCIRRHUS OF THE BREAST.*

BY MOSES GUNN, A.M., M.D., L.L.D.,

Professor of the Principles and Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago.

(*Specially Reported for the Maryland Medical Journal.*)

GENTLEMEN: Our first patient is one I called your attention to the other day; and this afternoon I propose to make a resection of a couple of ribs so as to effect not only a more complete drainage of the cavity, but to allow the ribs to approximate one another, and measurably close the cavity up. I have resected two ribs, and think I shall remove a little more from the upper one. I have simply laid bare the rib, denuded it of its periosteum, and it is now perfectly isolated. The object of this operation is to remove a portion of the bony brace or girdle which keeps the thoracic walls expanded. Now, you will notice, I put my finger directly into the cavity, and my aim in so doing is not mainly to secure better drainage, but to enable the chest to collapse, which cannot be obliterated by the expansion of the lungs—the lungs being so injured by the original disease. Now, I am enabled to withdraw it, and have here, as you see, an inch and a quarter of one rib, an inch of another, and some fragments, making the short rib equal to the long piece. The cavity of the chest collapses from the pushing of the diaphragm upwards at the abdominal viscera. In introducing my finger into the cavity I am enabled to feel around the left of the left lung, and a very small affair it is, indeed.

Now, how will the simple taking out of these ribs enable the chest to collapse? You will perceive readily enough that the two approximate one another just as a fracture or displacement, one fragment overrides another. But how can it take place to any extent when the rib below it is not resected? Of course, we want them separated. I had this illustrated not many months since, where I was enabled to see at once—before I got through the operation of resecting only one rib to enable it to come together, after pushing the fragments upwards—that the rib above came in close contact with the rib below. I had barely room for my drainage tube. The same thing will obtain measurably with regard to the ribs I have resected here to-day. It will enable the rib above the last one resected to settle down near the rib below; but in our former operation we shall have an irregularity of the chest. However, it will diminish the capacity of the thoracic cavity, and allow the walls to approximate one another, which we cannot fill up or supply by granulation tissue.

Vegetations of the Urethra.

This patient comes before us with vegetations of the urethra. You will remember that several months ago on examining her I discovered a little tumor projecting from the orifice of the urethra, which I removed. At a subsequent date Dr. Whitney removed some more, and about a month ago, with a curette, I removed all, as I thought, of these vegetations. I have seen the patient but once since, but told her at that time to come around and report progress. To-day she is complaining of much itching. Now, I certainly regard that, gentlemen, as a great improvement. It was not itching before; it was most decided, excruciating pain. To-day I think I shall prescribe for her simply a wash, to be used as an injection, saturated with a warm solution of boric acid, thrown into the urethra twice or thrice daily.

Pott's Disease.

This little fellow (age six) a year ago received a severe blow in his back over the spine from a stone being thrown at him. The father has endeavored to imitate his carriage to you, and it is a very peculiar one, as you see. He not only

*A Clinical Lecture delivered at the Rush Medical College Hospital.

assumes a one-sided position, but holds his back perfectly stiff, the motions being principally in the legs and pelvis. The father has also told us that when the little fellow sits down he always supports himself by putting his hands on his knees or some other object within reach, thus supporting that affected part of the spinal column. I now place an article on the table for him to pick up. In picking it up you notice that he throws the weight of the body upon the articular processes of the several vertebræ. He has had probably an inflammation of the bodies of one or more of the vertebræ. This is a case that requires treatment of some kind; and there is probably no better way with which to meet the requirements of the case than Sayre's plaster-of-paris jacket, the patient being suspended by the head and shoulders, while the weight of the body strengthens the column, and thus throws it in good condition. While we do not deny the fact that we have and will have cases of this disease occurring in good, healthy constitutions, it is nevertheless the result of mechanical injury or traumatism. We see many cases of this character traced to mechanical injuries. We recognize it in this case as a starting point of the disease.

We have a constitution here that needs building up, so we prescribe for him a good, generous, animal, vegetable and farinaceous diet, warm clothing, plenty of good, pure atmosphere, and out-of-door exercise to reasonable extent.

Congenital Valgus.

This case is clear at a glance. We bring the knees parallel or nearly so in order to see the position of the legs. We bring them together so that the internal condyles may touch one another. Now, you notice the position of the feet. We have a condition here that needs treatment, and what shall that treatment be? If the case had been brought under our observation at an earlier date, it no doubt could have been effectually treated by an apparatus—a well-fitted shoe upon the foot, a straight steel bar, the upper end of which is padded, to rest upon the trochanter major, with a rubber bandage so as to embrace the knee, and thus produce a continuous, slight, unyielding, unremitting pressure. If something of this character had been applied when the child was a year or so old, it would have been very efficient; but even now it may not be entirely ineffectual. The difficulty will be in getting one to render assistance in the case, to keep the apparatus constantly operative.

Another operation may be resorted to, which consists in altering the angle of articulation. You will notice it is abnormal, in fact, oblique instead of being horizontal, the internal condyle being too long when compared with the external one. We may correct this deformity by two operations. One I believe is known as Ogston's operation, which consists in chipping off a portion of the internal condyle, etc., which is somewhat hazardous; the other is McNamara's, which consists of opening the shaft of femur, removing a wedged-shape piece from the shaft of the femur close above the condyles, etc. The shaft of the femur is thus completely severed or very nearly so,the parts then being placed in their normal condition and secured by splints. The child is too delicate to stand any great surgical handling, and I confess I naturally shrink from resorting to either of these operations under her present condition. What, then, are we to do? Such being the case, I would advise the use of properly adjusted splints to see what could be accomplished in that way, and if they can carry it out they may succeed in correcting the deformity, or at least, improving it; and eventually, should they not be successful, when the child gets older, the other operations remain for us to fall back upon.

Epulis.

This patient has what is termed epulis. Opposite the right canine, lateral and both central incisors, we have a tumor developed at the free edge of the gum, which rises up and almost obscures the teeth. The patient informs us that

this has been noticed for over six weeks, and also tells us that it bleeds occasionally. This tumor consists of fungus granulation tissue, or neoplasm; and on examining her mouth I find the same thing upon the inner aspect of the jaw. The same disease is also beginning to appear between the posterior bicuspid and the first molar. To remove this growth, it becomes necessary for us to extract about six or eight of her teeth, or possibly the aveolar process may become involved.

Goitre.

This patient came before us three months ago with a pretty well developed goitre. She has submitted to several injections, and as you will notice, the enlargement is constantly and gradually diminishing.

Scirrhus of the Breast.

Our next case, age 53, has a general enlargement of the breast, more marked here upon the outer border than at any other point. The skin, as you see, is beginning to become a little corrugated. In passing my finger into the axilla, I find that it is clear of any secondary deposit. The lymphatic vessels leading up along the border of the pectoralis major are not painful at all, nor are there any enlarged glands surrounding the axilla; but our patient informs us that roundabout the nipple the pain is of an acute and lancinating character. Now, what is the disease? It is scirrhus of the breast and there is only one remedy, and that is a remedy which we have to eventually resort to, with some doubtful ultimate results attending the operation—the surgeon's knife.

On the occasion of the tercentenary festival of the University of Heidelberg, a large gold medal was founded for contribution to the scientific knowledge of the human eye. It has been awarded to Professor Helmholtz, of Berlin, for his discovery of the ophthalmoscope.—*Med. and Surg. Rep.*

Original Articles.

ON THE NUTRITIVE VALUE OF SOME BEEF EXTRACTS. AN EXPERIMENTAL INQUIRY.*

BY THOS. J. MAYS, M. D., OF PHILA.

During the last seven months my leisure time has been principally employed in efforts to determine the nutritive value of some of our principal beef preparations, and I beg your brief attention this evening for the purpose of bringing the results of these researches before you.

That there is no idea so erroneous as to be wholly devoid of truth, nor one so true as to be wholly devoid of error, is an ancient maxim, and its truth is probably as well illustrated in the prevailing ideas of the nutritive value of the beef extracts as it is in anything else. A study of the extensive literature of the beef extracts shows the inconstant and indefinite opinions which have been held concerning their action, and also illustrates the fluctuations of thought which the medical profession is liable to undergo. Liebig, who was one of the first to invest this question with scientific interest, held no less than three different theories regarding their action during the last twenty years of his life. In his *Letters on Chemistry*, published in 1851, he distinctly rates the beef extracts as nutriments—*i. e.*, as substances which are capable of supplying working force to the muscles of the body. In *Auerbach's Volkskalender* page 148, published in 1868, and in his *Chemische Briefe*, issued in 1865, he expresses the opinion that they are merely condiments (Genussmittel), and, hence, only act as stimulants to the process of digestion, and to the general nutrition of the body. Later, he conceived the idea that they are nutrients not only in the sense of supplying force to the body, but as furnishing material wherewith the bodily tissues are constructed. Since his death, however, medical opinion has by almost universal consent reverted to the second

*Read before the College of Physicians of Philadelphia.—Stated Meeting held Feb. 3, 1886. The President, Dr. S. Weir Mitchell, in the chair.

idea entertained by him, viz., that the beef extracts are of no or very little value as foods. It is true that this has been questioned by some whose clinical observations have led them to different conclusions, yet I do not know of a single work on physiology, therapeutics, or pharmacology, that does not assign the beef extracts among the non-nutritious alimentary agents. Probably the most positive expression of this feeling among those who are considered modern authority on such subjects is that of Dr. Fothergill in his *Handbook of Treatment*, or *Principles of Therapeutics*, who, on page 537, says that, "as a food, beef-tea ranks low. It contains meat-salts, a small quantity of albumen, and a little gelatine, together with some advanced nitrogenized matters useless in histogenesis. But there is little in it to repair tissues, and less in it to sustain life, so far as our knowledge yet extends. There is little real force-bearing material in the protean compounds of beef-tea. For the starving fever patient, to give him beef-tea alone is almost to give him a stone when he asks for bread. It makes him feel better for the time being, but that is due to its stimulant properties."

There can be no doubt that the cause of the prevailing scepticism concerning the nutritive value of beef extracts is largely due to the experiments which were made by feeding animals exclusively on these preparations, with the result that all of them died within a short period of time. Indeed, Kemmerich affirms that they died more quickly than those which were left to starve from hunger. This has the semblance of proof that beef extracts are not capable of supporting life. Sober reflection teaches, however, that no animal can subsist continuously on any single food, and that such a test would unceremoniously refute the food value of any substance no matter how nutritive it might be. But, beset with difficulties as this investigation evidently is, the question is not whether these substances are capable of sustaining life alone, but whether it can be shown that they contain any nutritive value at all, and if so how much. Here everything depends on the method which is employed to determine this question. It is imperative that this should be definite and exact. It must be able to show the functional state and condition of the organism, before, during, and after the addition of these substances; or, in other words, it must demonstrate whether the organism is, or is not capable of performing work when these substances are added to it.

To meet all these desiderata I selected the isolated frog's heart, which has already proved itself so pregnant with good results in the hands of Ludwig, Cyon, Kronecker, Bowditch, and others, in the full belief that it will show itself as capable here as it has in clearing up other problems in experimental physiology. Only quite recently Prof. Yeo (*Journal of Physiology*, vol. 6, No. 3, p. 93) has succeeded in demonstrating with it the reduction of oxyhæmoglobin, a phenomenon, the existence of which was assumed, but never proven by direct observation.

The experiences of Prof. Kronecker, Drs. Martius, McGuire, Von Ott, and others, show very cleary that when the frog's heart is well washed out with a 0.6 per cent. saline solution and then allowed to beat with the same, its pulsatoins gradually get less in force and in elevation, until at last in the course of an hour or two it becomes entirely exhausted and is unable to work any longer. But when this stage of complete fatigue is reached, and the heart is filled with blood or serum, it recommences to beat, and its pulsations gradually gather in strength and in elevation until their former altitude is attained. If, instead with blood, the heart were refilled with the saline, or any alkaline, acid, or even alkaloid solution, it would never show any sign of returning vitality. This observation means that the saline, alkaline, acid, and alkaloid solutions are devoid of material with which the heart can perform its function, and, although it works while it is filled with these solutions, it does so at the expense of the nutritive material stored up in its own meshes, and not with any energy derived from these solutions. Indeed, Dr. Pohl-

Pincus (see *Verhandlungen der Berliner Physiologischen Gesellchaft*, Feb. 23, 1883) has brought forward evidence which indicates that in the wall of the frog's heart their exist lacunæ (Nahrspalten) designed for the purpose of storing up nutritive material. As soon as this stored-up supply is exhausted, it ceases to beat, and any solution which is now applied to it with a view to reëstablish its pulsations must contain some elements which are capable of nourishing it. These essentials are found in the blood and serum of most animals. Dr. Von Ott (*Archiv fur Physiologie*, March, 1883,) has also shown that milk has the power of nourishing the heart. And Prof. Ringer (*Journal of Physiology*, vol. vi. No. 6), in following the same line of inquiry, found that both albumen and gelatine are capable of sustaining the heart's contraction. In my own work on the nutritive value of different concentrations of blood, performed in the Berlin Physiological Laboratory under the direction of Prof Kronecker (*pub. Verhandlungen der Berliner Physiologischen Gesellschaft*, Jan. 1883), I found that the amount of work of the frog's heart performed with blood depends entirely on the degree of dilution of the latter agent. Dr. McGuire found, however, that 1 : 3—*i. e.*, one part of blood to three parts of saline solution—gave the best results.

In summing up the literature upon the action of the frog's heart in its relation to our subject, we find the following: That the heart in performing work consumes oxygen; that after it is once completely exhausted, it cannot resume its pulsations unless food energy is supplied to it from the outside; that blood serum, milk, albumen, and gelatine are capable of acting as foods and of restoring its power of contraction, but no other substances have, heretofore, been shown to possess this property; that the pulse elevations and the amount of work which the heart is able to do, depend in a great measure on the degree of concentration of the food. These data, moreover, demonstrate very fully that the heart does not exercise the function of a purely circulatory organ in these experiments, but that it is an organic medium possessed of the power of assimilation, of transformation of energy, of contraction, and of respiration.

The apparatus which was employed in testing the food value of the beef extracts was the following: The heart, by means of a double cannula, on which it is securely but gently tied, is attached to a Kronecker-Bowditch heart apparatus, and then through a mercury manometer, and an appropriate glass needle, it records it pulsations upon a revolving cylinder. The heart is fed or transfused through the double cannula from two Mariotte's bottles, with any desirable fluid; and in order to keep it pulsating regularly, minimum shocks of one Daniell's cell through a DuBois sliding induction coil, were employed about every four seconds. Before testing the beef extracts, the heart was in every instance well washed out with a 0.6 per cent. saline solution, after which it was allowed to work with the same until all its stored-up material was exhausted and its pulsations reduced to zero. Then a weak solution of the inorganic elements of the beef extracts, chiefly containing phosphate and carbonate of potash, and chloride of sodium, was carefully tested on the heart to find out whether it had any power to induce cardiac contractions, but it failed in every instance. The same was also found to be true of a solution of urea whenever it was tried. After this preliminary work a number of different dilutions of a beef extract previously prepared with a 0.6 per cent. saline solution (usually in the following proportions — 1 : 100; 1 : 250; 1 : 500; 1: 666; 1 : 1000; 1 : 2000; 1 : 4000) were alternately introduced into the heart and their effects noted The stronger dilutions, like 1 : 100 to 1 : 500, had no influence whatever in restoring cardiac contractions, but in every specimen which was examined, the dilutions from 1 : 666 to 1 : 2000 had the power of reviving and of maintaining the beats of the heart.* The other beef preparations which were examined in

*Dr. Mays here gave an explanation of the tracings given by Valentine's Meat Juice which we are unable to present. EDITOR.

the same manner as Valentine's Meat Juice, were Reed & Carnrick's Beef Peptonoids; Parke, Davis & Co.'s Sarcopeptones; Johnston's Fluid Beef; Cibil's and Liebig's Extracts, besides milk, and all gave evidence that they possess nutritive properties. Although the amount of nutrition varies somewhat in each specimen, as will appear later on, every one gave tracings substantially similar to those given by Valentine's Meat Juice.

Judging from these data, I think the following deduction can be made concerning the influence of the beef extracts on the frog's heart.

1. That they are absorbed and assimilated.

2. That they contain material which has the power of inducing muscular contraction—a power which has heretofore only been shown experimentally to exist in the higher animal albumens or proteids.

3. That, hence, whatever else they may be, they are nutrients in the full implication of that term.

After it was thus demonstrated that these beef preparations contained definite nutritive properties, it was deemed desirable to ascertain the value of each, and means to this end were instituted by comparing their effects with those of a two per cent. solution of dried bullock's blood alternately on the frog's heart in the following manner: In the first place the heart, after being washed out, was filled with the two per cent. blood solution and then allowed to beat until its pulsations were reduced to a minimum, or until the whole nutritive supply of the blood solution was consumed; after which it was washed out again and filled with a solution of the beef preparation to be tested, and allowed to beat with it until its pulsations were again reduced to a minimum. A large number of comparative tests were made of each of the above named beef preparations in this way, and the following products were obtained, which indicate the mean percentage of the number of pulse beats given by each preparation, while that of blood is taken as 100. These figures are probably not absolutely true, but they give an approximate idea of the nutritive worth of these extracts when compared with that of a two* per cent. blood solution, which is capable of producing a normal cardiac contraction.

	Mean Percentage of Number of Pulse-beats.
Liebig's Extract of Beef	58
Johnston's Fluid Beef	59
Valentine's Meat Juice	60
Cibil's Extract of Beef	61
Sarco-peptones (Parke, Davis & Co.)	62
Beef Peptonoids (Reed & Carnrick)	74
Milk	100
Two per cent. solution of dried bullock's blood	100

From this table, it appears that all these preparations contain very nearly the same amount of nutritive material except the Beef Peptonoids, which contain from ten to fifteen per cent. more than the others. It must not be forgotten in this estimation that the Beef Peptonoids are not pure beef extract like the rest, but a compound of the latter with milk and gluten. Therefore, in order to get at the true value of this preparation it is important to test each ingredient. Milk alone gives as good results as the blood solution, as can be seen from the table, and there is no doubt that a portion of its valuable property is due to this agent.

The next question which arises in this investigation is as to which of the many organic bodies resident in the beef extracts this nutritive property is due, and I must confess, that principally owing to the difficulty of obtaining these organic extractives, this portion of the work remains incomplete, but I am making preparations however, that the inorganic elements of the beef extracts contribute no share to this result, for the phosphate of potash solution contains all these, and in every instance where this was tested it failed to bring out the least cardiac reaction. Hence, these can be left out of consideration.

When finely divided beef muscle is exposed to the action of about four or five times its own weight of cold water for four or five hours and then well pressed out, it loses from sixteen to twenty-four per

*Two per cent. solution of dried bullock's blood gives as good cardiac contractions as fresh blood in proportion of 1 : 3.

cent. of its original weight. In this watery solution is contained from two to fourteen per cent. of flesh albumen, while the remainder is made up of kreatin, kreatinin, sarkosin, sarkin, xanthin, carnin, inosit, fat, glycogen, and the inorganic elements; while in the residue there is left nothing but fibrous tissue, principally composed of muscular fibres and connective tissue, which is tasteless, rejected by animals, and entirely unfit for nutrition. Therefore, it is very probable that all the nutritive element of beef muscle resides in its organic extractives.

Now there cannot be the least doubt that the variable amount of albumen contained in the beef extracts furnishes some of the nutritive property displayed by them, but it is far from my intention to claim that this is exclusively due to it. Indeed, I have found altogether unexpected indications during the investigation which may, on further examination, throw some more light on this question. One thing however, remains steadfast throughout, and that is, if the albumen of flesh is not the sole nutritive element in these beef preparations, then some or all of the organic bodies which they contain must be nutritious, and can no longer be regarded as effete products of the animal body.

It is not necessary to point out, then, that the multitudinous composition of these extracts makes them a very valuable class of alimentary substances, both for nutritive and constructive purposes; and before closing this interesting subject, let me refer very briefly to the practicability of the subcutaneous introduction of these agents. I think it is quite evident now that these preparations are assimilated and utilized by the frog's heart without previously passing through a digestive process, and we have no reason for believing that this does not also obtain in the human organism; hence in conditions where the stomach has an intolerance of food, or where there is any hindrance to the introduction of the same through the primary passages the object of feeding the patient can readily be secured by introducing a suitable preparation hypodermically. A number of years ago I treated several such patients with Valentine's Meat Juice, which, on account of its complete solution in the normal state, is probably preferable for this purpose. I injected from fifteen to twenty minims three times a day with good effects. I failed, however, to keep a record of these cases, but recollect that one was a case of persistent vomiting caused by a severe blow on the head, and that after each injection the patient expressed himself as being stronger and feeling as if he had eaten something. Not the least irritation was produced at the point of injection, and I think this field deserves further investigation.

In conclusion, I wish to thank Dr. Marshall, of the University of Penna., and Dr. Leffmann, of Jefferson Medical College, for valuable aid in prosecuting these researches.

Society Reports.

THE BALTIMORE ACADEMY OF MEDICINE.

STATED MEETING HELD FEB. 16, 1886.

After the regular order of business

RAYNOD'S DISEASE (?)

Dr. A. B. Arnold related an interesting case that had recently come under his notice; it occurred in a man, a stoker on a steamboat. The patient presented the following lesions: From the first finger of his right hand the last two phalanges had disappeared and from the ring finger of the same hand the last phalanx had dropped off. On the left hand the last phalanx of the thumb was gone and the last phalanx of the little finger had loosened preparatory to spontaneous amputation. He considered this a case identical with three described by Raynod. All of whose cases occurred in men following the same occupation (Stokers) and all having lost portions of their fingers in a manner similar to Dr. Arnold's man.

The pathology of the affection is very

obscure. The patients complain of no pain whatever and as a rule are in a tolerably good general condition.

Around about the stump in Dr. Arnold's case everything was perfectly normal, not so much as a dry eczema being present. The only other lesion that he could detect on the man's body, was an ugly excoriation in the palm of the left hand, which he did not think bore any relation to the special condition referred to.

He had seen another case with a similar loss of portions of the fingers, but the condition about the stump suggested elephantiasis.

Dr. J. Edwin Michael said he thought he had seen the same case as the man had been making the rounds of the different hospitals in the city. It was his impression that the same case had been reported some time since in the *Journal of Cutaneous and Venereal Diseases* by Dr. Robert B. Morison, of this city. He said when he saw him that the lesion in the palm of the left hand, to which Dr. Arnold had referred, communicated with a sinus which ran for some distance up the forearm and from which pus could be squeezed, but when the patient left the hospital the palmar wound had entirely healed.

Dr. J. J. Chisolm had seen one of these cases some years since, but took it to be elephantiasis.

Dr. Michael agreed with Dr. Arnold in not thinking it of syphilitic origin.

Dr. Arnold said in answer to Dr. Chisolm's question. "How does it differ from leprosy?" that there is no anæsthesia, no false œdema, etc.

Dr. Henry M. Wilson wished to know if leprosy was not on the increase in this country.

Dr. Arnold said that recently several cases of true tuberculous, anæsthetic leprosy had been imported into this county and had been reported.

Dr. J. J. Chisolm said he recalled five cases of true tuberculous leprosy two of which occurred in persons with whom he was personally acquainted. These cases he had seen while engaged in practice of medicine in South Carolina. They occurred in natives, whose parents were also born in this country. They all occurred in white males.

Dr. J. Edwin Michael referred to a case reported by Dr. I. E. Atkinson which existed and had its origin in Baltimore City. It was in a white woman. This too was true tuberculous leprosy.

Dr. Frank Donaldson, Jr., then read his admission thesis entitled

DIAPHRAGMATIC PLEURISY.

It will be published in the April number of the *International Journal of Medical Sciences.*

URETHAN.

Dr. John R. Uhler called the attention of the Academy to the new hypnotic; urethan. He gets most favorable results from its use. It is not disagreeable of taste, causes pleasant refreshing sleep, and is devoid both of nauseating and bad after effects.

He gives it in doses ranging from five grains to twenty-five grains. Fifteen grains being the average. He substitutes it very effectually for chloral, pareldehyde, and opium. He has not used it as an anodyne but only as an hypnotic. Considers its effects intermediate between chloral and paraldehyde.

Dr. J. J. Chisolm referred to a case that illustrates the rapidity of restoration to sight after operation in cases of complete glaucoma. In this case vision was perfect after ten days.

SALICYLATE OF SODA IN IRITIS.

Dr. Samuel Theobald referred to some interesting results he had recently obtained by the use of salicylate of sodium in iritis, occurring in patients with a history of inflammatory rheumatism.

Three weeks ago a young lady had called to see him—she had a most intense plastic iritis—pupil perfectly immovable. She had only perception of light and could not count fingers at the ordinary distance. She was ordered sodium salicylate and in a few days she obtained much relief. This salt was then withdrawn and iodide of iron ordered. She did well until the end of several days when she reappeared complaining of the

same trouble which increased in intensity until at the end of two days she was in the same condition as originally. The salicylate was repeated as well as the atropia drops locally and mercurial inunctions to temples. Cathartics were ordered and in *two days* she was so very much improved that vision equalled $\frac{20}{64}$ and the media sufficiently clear to permit satisfactory inspection of the optic disk.

She had had some glaucomatous tension but this did not prevent his ordering atropia nor interfere with the physiological and therapeutical action of the drug.

Dr. J. J. Chisolm has had some astonishing results in these cases from large doses of salicylate of sodium. In choroiditis he gets remarkable results from the use of pilocarpine. Two decided sweats give pronounced relief.

SUDDEN DEATH FOLLOWING THE OPERATION FOR LACERATION OF THE CERVIX UTERI.

Dr. H. P. C. Wilson spoke of a case in which he was recently credited with being the cause of the death of one of his patients. The woman was from a malarious district, much run down, etc. She came to him to be operated on for laceration of the cervix uteri.

After treating her with tonics, etc., until her general condition was improved, he decided to operate and appointed the hour; shortly before the appointed time arrived the patient was taken with colicky pains in the abdomen consequent upon drinking a glass of milk—these pains were allayed by the ordinary measures and she then insisted upon his proceeding with the operation.

Local anæsthesia was obtained by the use of cocaine and the operation performed without accident. After completion of the operation the pains returned and were allayed by hypodermic injections of morphia. She spent a very restless night, and when he visited her the next morning he found her quite ill.

Later in the day an erysipelatous inflammation appeared in the skin of the external ear and became so intense that the patient succumbed on the next day. There was nothing whatever wrong at the seat of operation.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD FEB. 15, 1886.

Dr. Samuel Theobald read a paper entitled,

NOTES OF A SERIES OF CATARACT EXTRACTIONS BY VON GRAFE'S METHOD.*

DISCUSSION.

Dr. E. Mierhof listened to the paper with much interest. Especially was there one point that had impressed him, the fact that Dr. Theobald had used atropia in all of his cases before operating. Many writers recommend the use of eserine; they claim that it is much easier to make a clean iridectomy with a contracted than with a dilated pupil.

Dr. Theobald said his experience had been just the reverse.

Dr. Harlan gets a clean coloboma by trimming off all ragged edges at the extremity of the primary incision.

Dr. Mierhof gets the ragged edges back into the eye by stroking lightly over the corneal wound.

Dr. Hiram Wood says it is Dr. Chisolm's practice to pull them into position by inducing contractions of the pupil by the use of eserine.

Dr. Harlan asked Dr. Theobald if drops were used in the eye after each operation.

Dr. Theobald said if there is no reason for doing otherwise he does not remove the bandage for 3 days, then he instills atropia drops into the eye. He thinks efforts to release the shreds of iris from the corneal wound by stroking, has a tendency to bruise. He don't approve of pushing them into position by small instruments. He avoids ragged edges by making one single clean cut into the iris.

Dr. Frank Donaldson, Jr. then read a paper on

PNEUMATIC DIFFERENT IATIO N.

Dr. H. Clinton McSherry thought

*See Maryland Medical Journal, Feb. 20th, 1886.
†See Maryland Medical Journal, Feb. 13th, 1886.

the greatest therapeutic value of the Pneumatic Cabinet, as pointed out by Dr. Donaldson, was in the application of a medicated spray directly to the diseased tissues. He does not consider it an apparatus that should be placed in the hands of every one, as unless, used with extreme care, it is capable of doing extreme mischief.

He would like to hear from a series of cases treated by this method alone. Most if not all of those referred to by Dr. Donaldson were under other treatment at the same time.

Dr. I. E. Atkinson, read a paper on

SCARLATINAL NEPHRITIS.

Dr. Wm. H. Welsch thought Dr. Atkinson's paper contained many points of interest, especially the conditions found in these kidneys, and agrees with Dr. Atkinson in looking upon this form of renal affection as being of a specific nature. It is the only form of nephritis that has been thoroughly investigated. He considers the form of the affection to be a glomerulo-nephritis.

The tufts are swollen and contain cell infiltration due to proliferation of the epithelium between Bowman's capsule and that covering the tuft. These cells accumulate in the space between the tuft and the capsule and give rise to a *crescent shaped* acccumulation that seems to be typical of this form of nephritis. Again there is a small cell infiltration around the afferent arterioles of the glomeruli which cause a narrowing of the lumen, hence a lessening of the amount of blood going to the tuft and a consequent decrease in the amount of urine passed in this disease. He finds these conditions very constantly occurring.

The micrococci found in the kidney, he takes it, are the same as those found in the other acute infectious diseases that give rise to suppurative nephritis. They are in all probability the common organism of pus.

He thinks that in dropsies without nephritis the trouble resides more in the vessel-walls than in any derangement with the kidneys.

Dr. W. Winsey reported a

CASE IN WHICH THE PLACENTA WAS ADHERENT IN SUCCESSIVE LABORS.

Dr. W. H. Norris has seen a number of cases of adherent placenta and in all of them was he able to trace the cause to some traumatism.

Dr. Wm. A. Moale showed a cast of a knee-joint which illustrated the position taken by the limb when fracture of the internal condyle of the femur takes place, as was the case in the patient from whom the cast was taken. He reported the case because of its rarity. Agnew knew of but 15 cases ever reported.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING, HELD FEB. 8, 1886.

The President, Dr. W. F. A. Kemp, in the chair; J. M. Hundley, M.D., Secretary.

SERIES OF CASES TREATED ANTISEPTICALLY.

Dr. J. Edwin Michael related a series of cases treated antiseptically, the method used and why he used it. He said, what he understood by sepsis, was, a condition of the system produced by *living germs* floating in the air. They gain access to the wound and then produce the symptoms of septic infection so familiar to us all. Every means used to prevent such infection, be it the potent germicide, cleanliness or infrequent dry dressings should be classed under the head of antiseptics; for while they differ materially in their mode of action they all tend to the same end. Listerism, he thought, conveyed a far too narrow meaning and did its distinguished inventor great injustice. It has achieved the greatest success and would be more universally used, no doubt, were it not for its elaborate and tedious details. Salicylate of soda, thymol, iodoform and carbolic acid have each been used for their antiseptic properties. The two last named are invaluable and certainly worthy the rank they now oc-

cupy in the ever increasing list of antiseptics. Iodoform is convenient and easy of application, but like carbolic acid it must be used with some degree of caution, for when too freely used it produces deleterious effects upon the system generally, acting as an irritant poison. Later on the bichloride of mercury was introduced as the greatest of all germicides and antiseptics, and rightly too; for not one has been so extensively used and stood so well the test of time and increasing experience.

In its use, as with all efficient germicides, care is necessary that it be used in not too strong solutions and too freely; more especially is this the case when the extent of surface is great, as in the abdominal cavity and in major operations. All surgeons, of the present day of any note, use antiseptics in one form or another. Tait uses cleanliness, Gamgee infrequent dry dressings. They are both antiseptics in a sense, the infrequent dry dressings preventing the access of germs to the wound, while Tait with his scrupulously clean private hospital stamps them out and, therefore, needs no germicide. Had he to operate in a general hospital, Dr. Michael thought, simple cleanliness would not answer. In Baltimore we seem opposed to antiseptics; it is true we use a little carbolic acid and sublimate solution, but it is done in a haphazard manner. We have no systematised method, and if we believe in the germ theory and wish success, there must be a plan adopted and adhered to. Dr. Michael then suggested the method he had adopted, which in his hands had given entire satisfaction. In illustration we take amputation of a limb. The surgeons and all assistants bare their arms to the elbow and wash hands and arms in a solution of bichloride of mercury 1 to a 1000. All sponges used have already been soaked in the sublimate solution of like strength for a month or more. The limb is first washed with soap and water, then with the sublimate solution; all instruments are put in a hot carbolic acid solution, as the sublimate solution corrodes and takes the edge off of them. After the operation the wound is irrigated with the solution 1 to a 1000; if large 1 to 2 or 3000; all sutures are to be soaked in the stronger solution. The stump is then dressed by first sprinkling on iodoform, next is applied iodoform gauze, then McIntosh cloth and lastly a wad of cotton. This dressing is allowed to remain two or three weeks, provided no untoward symptoms supervene. If the wound be large a drainage tube is inserted and any bone cavity is sprinkled with iodoform. Does not use sublimate solution in the abdominal cavity fearing its absorption and poisoning the patient. Of the series of cases related several were major operations. In one the knee joint was opened to wire a fractured patella of one year's standing. Others of like gravity were related and each pursued an entirely *aseptic* course.

DISCUSSION.

Dr. J. I. Pennington asked Dr. Michael if he used the spray in operations upon the abdominal viscera.

Dr. Michael said he did not, for the reason that it was very inconvenient and costly and really did not think it of much use. Keith has given it up some time since.

Dr. E. G. Waters thought Dr. Michael's remarks quite opportune, but could not agree with him (*in toto*) as to the germ theory of sepsis. He was not entirely satisfied on that point and rather believed sepsis to be a typhoid state induced by some chemical process. Dr. Waters said while surgeon during the late civil war and at about the same time Lister introduced into the Paris hospitals his method now known as Listerism, he was using creosote ʒj to a pint of water as a detergent wash, not knowing anything at that time of organisms. He also used at that time Laborraque's solution but laid it aside for permanganate of potash which he used with good success. He varied the strength as indicated and used it as strong as 80 per cent. in gangrene. Gangrene was not often encountered, but pyemia was rather frequent and especially when there was bone wound. Erysipelas was common after amputations. Dr. Waters asked

Dr. Michael his experience with hospital gangrene.

Dr. Michael said he had not had any, since it was very uncommon with our present means of treating wounds. He had often had erysipelas but never lost a case and always treated it with tincture chloride of iron, which seemed to be a specific, causing it to subside as if by magic. One peculiarity he had often noticed in erysipelas and that was its attacking a part at a distance from the wound and remaining free of it during its entire course. In a patient whose skull he trephined for depressed bone, erysipelas occurred on the face, and in another whose fingers he amputated it occurred up the arm near the elbow; in neither case did it complicate the wound. Dr. Michael said that Dr. Waters in using his so-called detergent washes was in reality using antiseptics.

Dr. G. Lane Taneyhill asked Dr. Michael how soon after the first dressing should another be applied.

Dr. Michael said it varied, when it became dirty, and sudden or a high temperature, or rapid pulse, then it should be removed.

Dr. Taneyhill said he did not believe in meddlesome surgery and often demurred, during the late war while acting as surgeon, against the then too prevalent fashion of dressing wounds two or three times a day.

Correspondence.

PHYSICIANS' BILLS, PREFERENCE CLAIMS.

BALTIMORE, February 27, 1886.

Editor Maryland Medical Journal.

DEAR SIR:—In an editorial which appeared in your issue of January 23rd, 1886, you were kind enough to call my attention, in accordance with the wish of one of your correspondents, to the necessity of securing, if possible, the passage of a law, making physicians' bills, "preference claims" on the estate of a decedent.

Heartily approving of the suggestion, I immediately wrote to the Chairman of the Committee having in charge, at the time, the preparation of a Bill for the Regulation of Practice in Maryland, and earnestly urged them to draft an act for the purpose indicated in your editorial.

What action they took, I have not yet learned. In the meantime, I addressed an inquiry to my friend, Willoughby N. Smith, Esq., a gentleman whose legal attainments make him an authority in such matters, to ascertain what legislation, if any, in regard to this point existed on the statute books of other States, and he has, at no little trouble, investigated the subject fully, and sent me the following reply, which, for the benefit of the profession, I beg you to publish.

Very respectfully,

JOHN R. QUINAN,

President of the Medical and Chirurgical of Maryland.

BALTIMORE, February 27th, 1886.

DR. JOHN R. QUINAN,

President of the Med. and Chir. Faculty, of Md.

MY DEAR SIR:—Referring to your letter of January 23rd, I must ask your indulgence for the delay in undertaking to reply to the questions you therein addressed me. This delay has been due in part to the pressure of other engagements; and in part to the fact that the preferences you inquire about, if any, are given by the statute laws of the several States, and it has taken considerable time to examine the statutes of the several States for enlightenment.

So far as I have been able to discover, in none of the States is the claim of a physician for services rendered a deceased person given priority of payment in the settlement of administrator's or executor's account.

In this State the claims of physicians for services rendered the deceased in the line of their profession stand on the same footing as the general unsecured debts of the deceased.

There is this distinction between the claim of a physician and that of an undertaker: The services rendered by a physician are to the deceased in his lifetime, and are rendered under either an express or implied promise of the deceased to pay for them, it is his debt; the bill of the undertaker is contracted with the executor or administrator and the latter makes himself responsible individually and not in his representative capacity to the undertaker.

In Maryland, the executor or administrator is allowed a first credit for necessary expenses actually paid by him in giving deceased proper burial, according to the condition in life of the deceased. In all the States, the rule seems to

be that funeral expenses actually incurred indecently interring the deceased are allowed the executor or administrator in preference to all other claims. Where the deceased died solvent, and there is a residuum of his estate to pass to heirs or legatees a larger amount is allowed for funeral expenses than where the deceased dies insolvent. In the first case the rule is to allow expenses proportioned to the quality and station in life of the deceased.

It seems to me the bill you speak of has merit and should pass. The claim of a physician for services rendered deceased in the last sickness stands on the same footing as a bottomry bond. Such services by prolonging the life of the sick man tend to increase the fund out of which creditors are to be paid, and therefore is a service beneficial to the creditors themselves as well as to the patient.

Very truly yours,
WILLOUGHBY N. SMITH.

Reviews, Books and Pamphlets.

Sixth Annual Report of the Dispensary for Nervous Diseases. No. 6 Barnet Street, Baltimore. Press of Thomas E. Price. 1886.

The Sixth Annual Report of the Board of Trustees and Attending Physician of the Dispensary for Nervous Diseases is a document of some interest to professional readers. The report calls attention to the good work this institution is doing for a large class of cases afflicted with nervous diseases. During the fiscal year ending December 31st, 1885, 4,323 patients were in attendance, an increase of nearly 1000 above the report of the previous year. Dr. John Van Bibber, the Attending Physician, calls attention to the fact that the institution has outgrown its present accommodations and that it is absolutely necessary, in order to carry out fully the career which has been developed by the institution, that it should be enlarged and incorporated into a hospital. He urges this movement upon the part of the Board of Trustees and demonstrates that the expenses of this improvement would not be above $3,000.

Dr. Van Bibber refers to the fact that there is an unusual and marked increase in St. Vitus Dance and other nervous disorders among school children. Reference is also made to the fact that one hundred and three diseases of the nervous system were treated in the Dispensary during the year.

Practical Notes on the Treatment of Skin Diseases. By GEORGE H. ROHE, M. D., Professor of Hygiene and Clinical Dermatology, in the College of Physicians and Surgeons, Baltimore, etc. Baltimore: Press of Thomas & Evans, 1885. Pp. 59. Price, 25 cents.

The small volume before us is devoted to a study of the Diseases of the Perspiratory and Sebaceous Glands, including hyperidrosis, bromidrosis, prickly heat, seborrhœa, comedo, acne, acne rosacea, sycosis, and other disorders of the cutaneous glandular system. The author has attempted to give a brief and exact description of these diseases and to point out the most direct methods of treatment. The book has the merit of being thoroughly practical and useful for handy reference. The needs of the general practitioner have been kept in view in its preparation, theoretical questions having been entirely subordinated to plain matters of fact. The author announces that should this work meet with a favorable reception from the profession, it will be followed at intervals by similar contributions on other diseases of the skin.

BOOKS AND PAMPHLETS RECEIVED.

Materia Medica and Therapeutics for Physicians and Students. By JOHN B. BIDDLE, M. D., Late Professor of Materia Medica and General Therapeutics, in the Jefferson Medical College, Philadelphia. Tenth Edition, Revised and Enlarged, with Special Reference to Therapeutics, and to the Physiological Action of Medicines. By Clement Biddle, M. D., U. S. N., and Henry Morris, M. D. With numerous Illustrations. Philadelphia. P. Blakiston, Son & Co., 1886. Cloth, $4.00; Sheep, $4.75.

The Year-Book of Treatment for 1885. A Critical Review for Practitioners of Medicine and Surgery. Philadelphia. Lea Brothers & Co,, 1886. Pp. 307.

The Methods of Bacteriological Investigation. By FERDINAND HUEPPE, Docent in Hygiene and Bacteriology, in the Chemical Laboratory of R. Fresenius, at Wiesbaden. Translated by Hermann Biggs, M. D., Instructor in the Carnegie Laboratory, etc. Illustrated with Thirty-four Wood Cuts. New York. D. Appleton & Company, 1886. Pp. 214.

The Adirondacks as a Health Resort. Edited and Compiled by Joseph W. Stickler, M. D., Member of the New York Pathological Society, etc. New York and London. G. P. Putnam's Sons, 1886. Pp. 197.

Hospital Sisters and Their Duties. By EVA C. E. LUCKE, Matron to the London Hospital. Philadelphia. P. Blakiston, Son & Co., 1886. Pp. 163. $1.00.

HOW TO CURE FRECKLES.—M. Halkin, in the *Annales de la Société Médico-Chirurgicale de Liège*, recommends the following process for curing freckles. After the skin has been well washed and dried, the folds of the skin are drawn out with the left hand, and, with the right, carbolic acid is painted on the freckle, and allowed to dry. During some days the spots appear more evident than before the application of the acid, and a kind of epidermic scale is formed. In seven or eight days the scale falls off; the skin thus exposed is of a rose colour, but afterwards becomes white.—*British Med. Jour.*

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BALTIMORE, MARCH 6, 1886.

Editorial.

THE GENERAL SURGEON IN THE ABDOMINAL CAVITY. — The ovariotomists have shown the general profession that the peritoneal cavity is not so sensative but that it can be invaded with success for surgical purposes, and the developement of the technique of antiseptic surgery has made the operation of opening the belly, *per se* one of even comparative safety. The general surgeon has contributed no little to this advance in surgery, and, of late, has shown a distinctly aggressive tendency in the direction of the peritoneal cavity. Even Baltimore, which is said not to be the most progressive of cities, can boast of two successful cases of laparotomy for intestinal obstruction, both done by general surgeons and both reported at one of the meetings of the Clinical Society. Two notable papers have recently appeared which emphasise this tendency, one by Dr. R. F. Weir, read before the New York Surgical Society, on January 26th, on "Resection of the Large Intestine for Carcinoma," the other by Dr. F. S. Dennis, read before the New York County Medical Association, February 15th, on "Laparotomy in the Treatment of Penetrating Wounds and Visceral Injuries of the Abdomen." Dr. Weir bases his paper on a successful case in which he opened the abdominal cavity, resected about five inches of the sigmoid flexure, including a carcinoma, inverted the rectal end of the tube closing the stump with Lembert sutures, and brought out the lower end of the upper part of the gut through the abdominal incision forming an artificial anus. The patient, after passing through various vicissitudes, finally recovered and was discharged with no particular discomfort, save that dependent on his artificial anus. The existence of certain enlarged glands and an increase in the size of the liver pointed to a probable relapse, but the previously existing obstruction was relieved, the patient made comfortable, and his life unquestionably prolonged. Had the opportunity been afforded for an earlier operation a permanent cure might have been achieved. Dr. Weir furnishes a valuable table (*Medical News*, Feb. 13, 1886,) of the thirty-five cases of resection of the intestine for malignant growth which he has been able to collect. Fifteen recoveries are reported which, even allowing that a relapse should occur in many of the cases, places the operation upon a very encouraging basis, since they would all have been necessarily fatal without operative interference. Dr. Dennis includes in his paper the consideration of (1) penetrating stab wounds, (2) penetrating gunshot wounds, (3) rupture of the intestine. The first part of his paper, namely that on stab wounds, is all that we shall consider here. He bases his remarks on a case in which a man received a stab wound four inches above and three inches to the left of the umbilicus. A piece of omentum protruded from the wound. There was moderate shock, and it was, of course, impossible to accurately diagnosticate the state of affairs inside. Laparotomy was done and the contents of the belly thoroughly examined with, however, a negative result. The wound was closed, the patient's temperature did not rise above 99½° F. and he made a complete recovery.

The discussion in this case is based upon the propriety and safety of opening the belly for exploratory purposes in cases where penetrating injury has occurred and no satisfactory diagnosis can otherwise be made. Dr. Dennis is a strong advocate of exploratory laparotomy, and fortifies his position extremely

well with a series of fatal cases which presented similar symptoms to the one reported on admission to hospital, but which came to an untimely end under opium and conservatism, the post-mortem often showing that an exploratory laparotomy would have revealed a probably remediable condition, or would at least have given the patient the only chance for life. Dr. Dennis says: "The resolution to perform an exploratory laparotomy in stab wounds as a means of diagnosis, was not made suddenly, but was the result of much study and reflection, after an extended experience in the treatment of a large number of penetrating wounds." While we are not quite prepared to accept Dr. Dennis' views in regard to the safety of laparotomy, we think he has taken firm ground on the treatment of such cases as the one which he describes, viz: given a patient with a penetrating stab of the abdomen, the probability of his being benefitted by an exploratory laparotomy is greater than that of his being injured by it. It is worthy of remark that these two eminent surgeons attach the greatest importance to antiseptics, and all that is said of the comparative safety of laparotomy is based upon the assumption that it is to be done under the most rigid antiseptic precautions. Should it become the fashion for general surgeons, who are not prepared to avail themselves of all the advantages afforded by a complete antiseptic technique, to make exploratory laparotomies, we have little doubt but that opium and conservatism would soon regain their former sway in the treatment of wounds involving the abdominal viscera.

"Clean out the Primæ Viæ."—Many of the readers of this Journal will recall this familiar aphorism which a late lamented teacher in this city was accustomed to enjoin upon the many students who attended his lectures. The often-repeated expression has passed into a proverb as one of the characteristic sayings of this careful observer and student of nature. As the result of a large clinical experience the lamented Professor, to whom we refer, had observed the extreme importance of cleaning out the *primæ viæ* as an introductory method to the treatment of many of the conditions witnessed at the bedside, and with that terseness and frankness, which were so characteristic of his style of teaching, he drilled this favorite aphorism into the minds of his students that they too might understand its importance and value. That saying which appeared to many as a mere habit of speech conveyed a most instructive lesson in the practice of medicine, and has, no doubt, led to the very best results in the clinical work of those students who have since enforced its practice at the bed-side. The importance of cleaning out the stomach and intestines should be more rigidly taught than is perhaps the case, for it is not difficult to over-estimate the beneficial effects which are likely to be obtained from those agents which excite the intestines to perform their full function in casting off the substances which may be undergoing decomposition within their walls. There are few practitioners who have failed to witness the benefit to the patient from a free catharsis, for clinical observation not only demonstrates the judiciousness of those methods of treatment, which have for their object the stimulation of the emunctories, but physiological chemistry points out the importance of the command "clean out the *primæ viæ*." It has been known for some years that there exists in animal substances undergoing decomposition a poison of extreme activity, whose toxic properties may prove as damaging to the economy as those poisons introduced from without. In fact the *leucomaines*, discovered by Gautier as far back as 1870, have been shown to have an action similar to strychnia, being capable of producing stupor, tetanic convulsions, cardiac irregularity, and finally death. According to this authority, there constantly appear in the excretions of the living and healthy animals, bodies, similar in nature to the ptomaines, which have been recognized as fixed cadaveric alkaloids of highly toxic properties. To the alkaloids which have been found in saliva and muscles Gautier gives the

name of *leucomaines* to distinguish them from the *ptomaines* or cadaveric alkaloids. According to this authority these various alkaloids may accumulate in the blood, when the skin, kidneys and intestines fail to eliminate them. These alkaloids are incessantly formed during health and are just as capable of producing anto-infection as the other products of disassimilation, urea, carbonic acid, etc.

Gautier claims there are two methods of combatting the poisonous influences of the leucomaines; first by elimination and, second, by oxygenation. Elimination may take place by the kidney, by the skin and by the intestines, hence the importance of promoting the healthy functions of these organs. By oxygenation, he claims, they are burned in the blood and, perhaps, also in the tissues; whatever, therefore, diminishes the access of air to the blood or diminishes the hæmoglobin will promote the accumulation of the azotized substances of the nature of ptomaines and leucomaines in the economy. On this theory Gautier explains the nervous troubles of chlorosis, anæmia and pregnancy.

There can hardly be a doubt as to truth of the facts stated by this eminent experimenter. Call these azotized substances by what name you please the fact of their existence and of their poisonous influence cannot be questioned. Clinically speaking there is abundant proof of the poisonous influence of re tained excrementitious substances, and the aphorism, "clean out the *primæ viæ*" is an injunction of more vital importance than many practitioners are prepared to admit. We might insist still further upon the importance of this principle of therapeutic practice, but the idea of provoking the oxygenation or elimination of the leucomaines has been so clearly demonstrated by Gautier that it seems almost useless to urge the acceptance of such rational views.

A new journal, called *The Neurological Review*, to be edited by Dr. J. S. Jewell, of Chicago, is announced to make its appearance between the 15th of April and the 1st of May.

Miscellany.

Hypertrophy of the Breast.—Dr. Speth, of Munich, has described, in a recent number of the *Münch. Aertlich. Intel. Blatt*, an instructive case of this disease, under the care of Professor Helferich. The patient was subject to a steady hypertrophy of the right breast during every pregnancy; after labour, the enlarement remained stationary for about six days, and then decreased, but the breast never returned to its natural size. The enlargement was accompanied by severe pain. She was 26 years old, and had been five times pregnant in the space of five years and a few months. The weight of the breast towards the end of the fifth pregnancy was about twenty pounds, and its greatest circumference over twenty-five inches. It hung down to the anterior superior spine of the ilium. In its substance, six large tough glandular lobules could be detected. It secreted no milk, though the left breast was in perfect order during lactation. Dr. Speth considers that pure hypertrophy of the breast is exceedingly rare, most alleged cases being instances of hypertrophy accompanying fibroma or sarcoma; indeed, he declares that an indisputable case is unknown. Even the hypertrophy itself appears to be invariably associated with chronic inflammation and serous infiltration. The interstitial connective tissue is greatly increased, and, at the end of labour, it begins to contract, so as to cause atrophy of the glandular substance. No treatment, excepting amputation, is of any avail; Professor Helferich's patient refused to undergo that operation. On the other hand, the only danger to which a patient with this affection is exposed, is the chance of very acute inflammation after labour.—*Br. Med. Jl. Feb.* 6, 1886.

The Penalty for Malpractice in China.—For engaging in the practice of medicine in China no license is required, but the lot of the unsuccessful physician is not one to be envied. The following is the two hundred and ninety-seventh section of the penal code which deals

with these unlucky practitioners: "Whenever an unskillful physician, in administering medicines or using the acupuncture needle, proceeds contrary to the established forms, and thereby causes the death of the patient, the magistrate shall call in other physicians to examine the medicines or the wound. If it appear that the injury done was unintentional, the practitioner shall then be treated according to the statute for accidental homicides, and shall not be allowed any longer to practice medicine. But if he have designedly departed from the established forms, and have practiced deceit in his attempts to cure the malady, in order to gain property, then, according to its amount, he shall be treated as a thief; and if death shall ensue from his malpractice, then, for having thus used medicine with intent to kill, he shall be beheaded."—*Med. Record.*

On Hysterectomy. — Dr. Thomas Keith, (*Edinburgh Medical Journal*, May, 1885) while recognizing the marvellous improvements and results of the last ten years in operative interference in cases of fibroids, yet takes a thoroughly conservative view, and advices the operation of hysterectomy only in extreme cases. The removal of the ovaries and tubes, he says, is an operation full of promise, and, as regards his own work, the result is more satisfactory every time that it is performed. It will not, however, supersede hysterectomy, as there are cases in which, even when got at, the ovaries cannot be separated from the uterine tumor without too great a risk. He advises trying the simpler method first, in all cases where the tumor is small, and does not extend much above the umbilicus. The proportion of cases in which interference of any kind is warrantable is, perhaps, not greater than five per cent. The cases in which he thinks hysterectomy may reasonably be recommended are these:

(1) In very large, rapidly-growing tumors of all kinds in young women.

(2) In all cases of real fibrous cystic tumors.

(3) In most cases of œdematous fibrous tumors which are not cured by removal of the ovaries. They occasionally grow to be very large, even weighing two hundred pounds, according to the author. Sometimes, large quantities of red serum can be removed with much relief, and in this way, the patients carried over the menopause, when the necessity for further puncturing ceases.

(4) In cases of large, bleeding fibroids, when removal of the ovaries cannot be accomplished, provided that the patient is not approaching the menopause. In these cases, as a rule, though there are many exceptions, menstruation goes on much beyond fifty.

(5) In certain cases of tumors surrounded by much free fluid, the result of peritonitis, provided that the fluid shows a tendency to reaccumulate after two or three punctures. Occasionally, when the fluid does disappear, its absence may, from some change in the osmosis, be followed by an extremely rapid growth of the tumor. It is important to remember that long-continued irritation of the peritoneal surfaces by large, solid tumors, is apt to be followed by degeneration of the peritoneum of a sarcomatous or cancerous nature. The microscopic examination of the fluid will, in such cases, keep one from falling into error. Dr. Keith has several times, where large, healthy, uterine fibroids were present, removed fluids swarming with cancerous elements, the source of which was found to be altogether in other organs affected with cancerous disease.

Then follow the histories of several operations, which are of use in showing the different ways of treating the attachments of uterine fibroids, or illustrating some other point of interest.—*Boston Med. and Surg. Jl.*

Artificial Suppression of the Menses.—Loewenthal, (*Centralb. für Gynäkol. No.* 40, 1885) in a paper read before the Fifty-eighth Meeting of German Naturalists and Physicians, at Strassburg, attempts to show the practical side of his new theory of menstruation. He first speaks of the method of suppression of the menses, which consists in rest in

bed, and hot-water injections. These should have a temperature of 50° C. (preferably, more), as he has observed that at a temperature of 46–47° C., they favor hæmorrhage. The rest in bed should be maintained for some time after the cessation of the flow. In a few cases, he has found cold water more effectual than hot in checking the menstruation. Then follow the details of twenty-three cases, which he had the opportunity of observing for a long time. Eighteen of these were well-marked cases of chronic chlorosis and anæmia, with very troublesome nervous complications, such as severe nervous dyspepsia, general hysterical symptoms, hysterical convulsions, and two cases of hystero-epilepsy. Of the remaining five, two were cases of marked hysteria, and three convalescent from debilitating diseases. In the case of these last, a quicker convalescence was the object of the treatment, and the author thinks it was attained. In the eighteen chlorotic cases, marked improvement began directly after the first suppression, without any other medication, and recovery occurred after from the second to the eighth. Of the two cases of hysteria, one became much better, the second not. In all these cases, the nervous, dyspeptic, and hysterical symptoms appeared after the beginning of menstruation, and were worse at each period. Loewenthal has never seen any bad results follow this treatment.—*Boston Med. and Surg. Journal.*

Changes in the Faculty of the Medical Department of the University of Maryland.—In consequence of the death of Professor Richard McSherry, which took place in October, 1885, the chair of Practice of Medicine in the University of Maryland, which he had so long and faithfully filled, became vacant. During the illness of Professor McSherry, Professor S. C. Chew was transferred to the chair of Practice, and during the present session he has delivered a most popular and acceptable course of lectures to the class. We are pleased, now to announce that Professor Chew has recently been elected, by his colleagues in the Faculty of the University, to the chair of Practice of Medicine, which act is not only a just recognition of his eminent fitness for this position, but an honor most appropriately bestowed by the school. It will be remembered by some of our readers, that for many years the chair of Practice of Medicine in the University was ably and efficiently filled by the late Professor Chew, the father of the present incumbent. The mantle which the father wore with eminent dignity and grace has fallen upon the shoulders of the son who combines in his attainments and character the earnestness, culture and skill as a teacher which were so markedly characteristic of his distinguished father. We are also able to announce the transfer of Professor I. E. Atkinson from the chair of Pathology in the University, to the chair of Materia Medica and Therapeutics in the same school, which latter position Professor Atkinson has very acceptably filled during the present course of lectures.

Kollerina.—To the enterprise of many pharmaceutical chemists the profession is indebted for a number of excellent and reliable preparations which have the merit of presenting well-known therapeutic agents in such combinations as add not only to their therapeutic effect, but to their facility of administration. The preparation known as *Kollerina*, is a combination of coca, celery, chamomile and sherry wine, so prepared as to make a palatable and excellent nervine stimulant and tonic.

Kollerina has been brought to the notice of the profession by Mr. John M. Wiesel, a well-known and reliable pharmaceutical chemist, of this city, who very modestly requests the profession to give it a fair trial. The preparation is simply a superior *wine of coca*, containthe ingredients above mentioned.

Causes and Treatment of Quinsy.—Having been in years past a frequent sufferer from quinsy I have taken special interest in it and can, after twenty years of experience, speak with confidence as to the correctness of my present views. First, it is essentially

a disease of debility, and is more or less associated with *adolescence* and a strumous habit. The exciting causes are sexual excesses, bodily fatigue, irregularity of meals, long continued fasts—or, in other words, excessive nervous or muscular exhaustion. Cold and rheumatism play little or no part in its production—nervous and muscular exhaustion are the immediate causes of quinsy, and both these make the person liable to take a chill and so rheumatic fever. However, I have rarely, if ever, seen these two coexisting in the same person. Again, it cannot be the result of a cold acting directly on the throat, because laryngitis would then be a much more frequent accompaniment than it now is, and a second attack rarely follows till after the lapse of some months, no matter what the amount of exposure. The *treatment* I advise can scareely be termed otherwise than a specific one, since I can with perfect truth affirm that very few, if any, of the cases have gone on to suppuration which have come to me at an early period. The effervescing citrates will be found useful in allaying not only this, but all other kinds of glandular inflammations, and I order 20 grains bicarbonate pot. with 15 grains of citric acid every four hours in state of effervescence. Guaiacum is best given in the form of lozenges made up with black-currant jam. One lozenge should be sucked frequently. Iodine, when applied locally in cases of glandular inflammation, is known either to reduce the enlargement or to hasten suppuration, according to the stage in which it exists; and a gargle, containing from 20 to 25 minims of tincture to the ounce of water, will be found particularly useful. This may be used by taking a little in the mouth, and shaking the head from side to side. Port-wine is an essential part of the treatment, and it is necessary for the patient to take from four to six ounces in the course of the day, besides plenty of beef-tea and milk. By this method resolution is almost always brought about, and the patients are, with scarcely a single exception, able to resume their usual duties about the fourth day. The usual duration under old methods was almost always from nine to ten days. Do not be discouraged if the patients complain of feeling no better, or even worse, for the first two days, but persist with it all the same. Though the bowels are almost always confined it is not advisable to administer aperients, since as soon as recovery takes place they are moved as regularly as possible, without extraneous assistance. When suppuration has commenced in the tonsils (which may be looked for about the sixth day, and made out by great throbbing in the ear on the affected side) it is best to omit the effervescing citrates and guaiacum lozenges, and depend upon the iodine gargle, together with port-wine and beef-tea. Suppuration is by this means hastened and suffering curtailed. I would ask those who put this method of treatment on trial, to keep a record of their cases, and make a report of the successful and unsuccessful ones, that we may arrive at really truthful conclusions.—*Dr. F. P. Atkinson in the London Practitioner.*

Soothing Application in Neuralgia.—Mayet has presented, before the Sociètè de Thèrapeutique, the following formula for a very neat and compact local application for use in neuralgic affections:

Chloral hydrate.....	5 parts.
Crystallized menthol...	5 "
Cacao butter.....	10 "
Spermaceti.....	20 "

These constituents are mixed into a paste, which is divided into pieces about two-fifths of an inch square, and weighing about thirty grains.

Chloral thus applied in cacao butter has no local irritative effect. The part affected is to be gently rubbed with one of the squares, which is then allowed to melt at the most painful point.—*Journal de Médicine de Paris.*

Resorcin in Epithelioma.—Dr. Antonio, of Mazzoro del Vallo Maggio, claims to have cured a case of extensive epithelioma of the face, by the use, twice a day of an ointment consisting of fifteen parts of resorcin to twenty parts of vaseline.—*Exchange.*

Medical Items.

The *Journal of Nervous and Mental Diseases*, will be issued in the future as a monthly periodical. This Journal is now edited by Dr. B. Sachs, of New York.

Dr. Angus Macdonald, a widely-known physician of Edinburgh, Scotland, died on the 10th of February at the age of fifty years. He was an able contributor to the literature of Obstetric Medicine.

The Annual Commencement of the College of Physicians and Surgeons, of Baltimore, will take place on Monday, March 15th, at the Academy of Music. The address to the Graduating Class will be delivered by the Rev. Mr. Jones, of this city.

The Seventy-ninth Annual Commencement of the University of Maryland will be held at the Academy of Music in this city, on the 17th of March, at 12 o'clock M. The address to the Graduating Class will be delivered by Col. William Allen, President of the McDonough Institute.

The Thirty-seventh Annual meeting of the American Medical Association, will be held in St. Louis, Mo., on Tuesday, Wednesday, Thursday and Friday, May 4, 5, 6 and 7. This meeting bids fair to be one of great interest on account of the controversy which has grown out of the International Medical Congress.

Dr. Domingos Freère, of Rio de Janeiro, claims to have vaccinated 6000 persons with his virus for the prevention of yellow fever and that not a single person inoculated has contracted the disease, although many of them lived in the midst of the epidemic and some acted as nurses for those ill with it.

The Washington correspondent to the *New York Medical Journal* says an epidemic of house building has struck the medical fraternity in that city with unaccustomed vigor, "Dr. Thomson, Dr. Hagner, and Dr. Prentiss have new residences in progress, and Dr. Sower and Dr. Bayne have just completed theirs."

"My poor man," said the doctor, "you are dangerously ill. Is there any word you want to send to your friends?" "Am I really so ill?" asked the sufferer. "Alas? I can offer you no hope." "Very well, then," said the sick man, "just telephone for another doctor." *Med. and Surg. Reporter.*

Dr. Stewart Elridge, who is practicing medicine in Japan, writes to the *Medical Record* that he receives numerous letters from physicians in America, who seem to think Japan an El Dorado. In answer to these letters of inquiry Dr. Elridge replies in a doggerel of some length. The closing words are significant.

"Unless Dr. M—— has good greenbacks galore
To fling to the winds on this far-distant shore;
Or, unless he can live, like old Tanner on air,
As he's in God's county—God! let him stay there."

The following combination is said to be useful: Sublimed sulphur and bitrate of potassium, each thirty grains; powdered resin of guaiac, fifteen grains; to be divided into four boluses. These may be taken at intervals during the twenty-four hours when it is desired to maintain a more or less profuse diaphoresis. —*Med. Record.*

The Annual Commencement of the Baltimore University School of Medicine took place at the Academy of Music, on Thursday, at 12 M. Rev. F. W. Gunsaulus delivered the oration. Diplomas were awarded to twenty graduates. The Faculty prize, a gold medal, was awarded to D. W. Jones, of Pennsylvania; the Hoopman prize, a gold medal, to J. J. Jackson, of Pennsylvania, the Biedler prize, a case of surgical instruments, to J. J. Brown, of Baltimore, and the Reuling prize, an ophthalmoscope, to J. J. Brockbank, of Pennsylvania.

The Sixth Annual Commencement of the Baltimore Medical College, will be held at the College Building, 225 and 227 North Howard Street, in this city, on Monday, March 8th, at 12 o'clock M. The address to the Graduating Class will be delivered by Professor Charles G. Hill, of the Faculty. The Diplomas will be presented by the President of the Board of Trustees, the Hon. Stevenson Archer. The Dean, Professor Lee, will at the close of the exercises, make a statement of the progress of the school. At 8 P. M. a banquet will be given to the Graduating Class, at the Carrollton Hotel, by the Faculty.

The *Weekly Medical Review* published in St. Louis, after repeated changes in its editorial management, has finally passed into the editorial control of an Association of physicians, composed of many well-known men in the West. Each member of the Association will be entrusted with a proportionate share of editorial work. We wish our contemporary success under its present management, but, if we may be permitted to venture an opinion, we will say that in such a union of medical talent as the *Review* calls to its assistance there will be only partial strength. The majority of these editors will work enthusiastically for awhile, but one by one will fag in interest. It will be the old aphorism repeated, "Too many cooks spoiled the broth."

Dr. E. O. Shakespeare, who was appointed by the President of the United States a special commissioner to visit the cholera districts of Europe and investigate the disease, after performing his mission commendably, is expected to return to us within the next two weeks brimful of valuable information.

A movement is on foot, headed by Dr. Levis, Dr. M. S. French, and other prominent members of the County Medical Society, looking to giving Dr. Shakespeare a suitable and certainly a well-merited reception. It is expected that distinguished national, state, and municipal officers will take part in this deserved reception of our distinguished commissioner. We look forward eagerly for the valuable information which Dr. Shakespeare will bring us.—*Med. and Surg. Reporter*, Feb. 27th, 1886.

Original Articles.

HEMORRHAGE OCCURRING THIRTEEN DAYS AFTER DELIVERY.*

BY J. M. HUNDLEY, M. D., OF BALTIMORE.

I was called to see Mrs. H. on the 29th of September last, and found her in her first labor at term; the presentation was the usual one. The second stage progressed favorably, save that I had to assist the efforts of nature in delivery of the shoulders. As the head of the child emerged from the vulva I ordered a dram of fluid extract of ergot to be given, which is my usual custom. The second stage of labor being finished, and 15 or 20 minutes having elapsed, I proceeded to deliver the placenta. Having never had any trouble in that direction, and believing that any placenta could be delivered by the method of expression, (if not all, certainly the majority) I went about it with little, if any anxiety; with my right hand grasping the fundus uteri, keeping up firm pressure, I inserted the fingers of my left into the vagina to take away the placenta, but to my surprise, it still remained within the uterus. Being taught that one's hand should never enter the uterine cavity unless absolutely demanded, I made traction upon the cord at its insertion, still keeping up firm pressure from above; as I did so the mass began to move, and the most of it was soon within the vagina. I however, found that some part of it still remained adherent, and as I was about to introduce my fingers to tear it away, there came a firm and strong contraction of the uterus. I tried to force my finger through the constricted cervix, but without success. I then waited some 15 or 20 minutes hoping it would relax, but it did not. I tried again to dilate with my fingers and again failed. My patient by this time, as you may well imagine, was pretty well wrought up, having heard various stories as to what would happen if the after-birth did come away, etc. I took away all that I could, leaving a piece about the size of a small hen's egg. I did so with great reluctance, I can assure you, and had not my patient become so very nervous I would have used other means to have gotten it away. I did no more, and hoped that what remained was not firmly adherent, and in twenty-four hours would be thrown off. My patient was made comfortable, and in an hour I left the house, telling the nurse to save all the clots, etc. that might be passed, for my inspection. No clots were passed, and at each visit I fully expected to hear that she had had a chill, the beginning of septic infection, but luckily she remained absolutely free of fever, ate and slept well, and got up on the ninth day apparently well. It is needless for me to say that I gave the case unusual attention, for it was one in whom I was much interested aside from the existing complication.

I gave fluid extract of ergot, in small doses, and used pads of absorbent cotton moistened with sublimate solution, 1 to 4000, over the vulva. As I have said, I paid my last visit on the ninth day, bidding my patient goodbye and feeling very much relieved, but still I could not account for the piece of placenta which remained in the uterus. I however, came to the conclusion that it had either been thrown off *en masse*, or undergone decomposition and come away with the lochia. On the thirteenth day after her confinement I was sent for in a great hurry, and on entering the room I found her very much excited, face blanched and bathed in a cold perspiration, pulse rapid and small, having had quite a free hemorrhage. I made an examination at once, and found the vagina and uterus filled with blood clots; these being removed I could distinctly feel the piece of placenta, which was as firmly attached to the uterus as if it were a part of it. With a good deal of effort, pressing the uterus down with my right hand, I finally succeeded in detaching it—a piece about two and a half inches long by one, and evidently the edge. I kept her in bed for five days, using ergot and hot water injec-

*Read before the Baltimore Medical Association, Stated meeting held Feb. 22nd. 1886.

tions. She had no return of hemorrhage while in bed, but as soon as she was up and began to move around it returned, worse at one time than another. Believing that I had removed all of the placenta I was at a loss to account for the continued hemorrhage. I now decided to curette the uterus. I introduced a trivalve speculum and with the ordinary uterine dressing forceps, succeeded in dilating the the cervix sufficiently to operate. Thomas' wire curette was used, and as soon as it was introduced I could feel that the uterine walls were studded with "vegetations"; as I would draw the curette along I could feel the little blood vessels give way. A second operation was necessary before complete recovery, and up to this time she has had no further trouble.

Now the first point in the case to which I would invite your attention, is; did the *ergot* induce the firm and persistent uterine contractions since sufficient time had elapsed from its administration for it to have been having its fullest physiological actions? If the ergot had not have been administered so early in the case, would not the cervix have remained sufficiently dilated or dilatable as to allow the extraction of the placenta? I can but believe that the ergot was responsible for the tonic contraction, and it has taught me a lesson not to be in a hurry to administer it. With our present knowledge that *Squibb's* fld. ex. of ergot can be administered hypodermically and will act in a few minutes, I see no reason to fear post-partum hemorrhage, and that seems to be the only object in administering it as the head emerges from the vulva.

2nd—Should the cervix have been dilated then and there, and the adherent portion of placenta removed? Playfair and several other authors say: Allow the part to remain; it is more than probable that it will be thrown off within twenty-four hours, and if it is not, it is then time enough to act. My patient had no fever and did well; in fact, better than the average puerperal woman, and I therefore saw no reason to interfere.

3rd—It goes to show that in this class of cases, it is only a waste of time to administer uterine hæmostatics when a few strokes of a suitable curette is all that is necessary, and void of danger when properly and delicately used. I would say in conclusion, that ergot and hot water injections were used freely to arrest the hemorrhage, and kept up for a week or ten days, as my patient was much opposed to any operation for its relief.

In my endeavors to deliver the placenta, very little extractive force was used, and the time that elapsed from the delivery of the child to that of placenta was fully an hour I relate this for fear some of you may think that I was in too great a hurry, and, had time enough been given, the uterus would have relaxed, and the placenta been delivered without trouble.

THE WATERY DISCHARGES OF PREGNANT WOMEN.*

BY CHARLES WARRINGTON EARLE, M.D.
OF CHICAGO.

Mrs. F. K., consulted me for a profuse watery discharge which had taken place several times during her pregnancy, commencing at the third month. She was the mother of three children, and had always been free from any marked pelvic disease. The first discharge was clear and watery, and she estimates the quantity at about two quarts. This came away in a gush, most of it being discharged at once, although there was a slight loss for some days thereafter. At first it was thin and clear, then slightly thicker, of the color of weak coffee. These discharges seemed to occur every two or three weeks, and were frequently attended with considerable pain. There was a decided diminution in the size of her abdomen after each discharge.

On October 30th, I found her in great pain, and an examination demonstrated that the fœtus was very low in the pelvis and apparently not surrounded with any *liquor amnii*. The *os uteri* was neither

*Read before the Gynæcological Society of Chicago, January 15, 1886.

soft nor dilated. She was ordered anodynes and to remain in bed. On the 7th of November, I again saw her, and found she had been having more or less pains since my previous visit. There was no dilation. Two days after, however, she was delivered, her gestation having lasted about 200 days. The child lived about one hour. She made a good recovery and resumed her place in her family in the course of two weeks.

Mrs. M., 27 years old; in her ninth pregnancy. At the end of five months she commenced to have a flow of fluid which continued until the end of the seventh month, when she gave birth to twins, one living and the other dead. There was no escape of *liquor amnii* at her confinement. The same lady in her eleventh pregnancy commenced to lose fluid at the end of the seventh month, which continued until the completion of the full term when she gave birth to a healthy child. She had what her attendants called a dry labor.

Mrs. D. W. R., aged 31, the mother of nine children, has been pregnant since the 1st of July, 1885. On November 20th, she said to a friend who was at her bedside that she was flowing and asked to be supplied with a napkin. A sheet folded and placed under the patient was thoroughly saturated with fluid; the discharge being equal probably to at least two pints. She had severe pains, which simulated those of labor, lasting a few hours. On December 15th, she had a similar discharge. The future of this case is yet to be decided.

Frequency. — These cases evidently take place with more frequency than we have, up to this time, supposed; but the older obstetric authors have noticed pecularities of this kind, and given very fair descriptions of the complications.

Smellie says: (page 179, Vol. II.) "Dribbling of fluid may go on for weeks, but a sudden gush is invariably followed by parturition, the longest interval between a sudden gush and labor being seven days." In this he is certainly mistaken, as the history of many recorded cases and some of mine will demonstrate.

Denman, 1815, says: "Instances have been recorded in which the waters of the ovum are said to have been voided as early as the sixth month of pregnancy without prejudice either to the child or the mother. The truth of these reports seems to be doubtful, because where the membranes are intentionally broken, the action of the uterus never fails to come on. A few cases of this kind, somewhat similar, have occurred to me. A discharge of colorless fluid takes place, daily, from the vagina for several months preceding labor, which is due to the rupture of some lymphatic. Such labors are usually premature and the fœtus small."

The same authority also cites a case where, after the delivery of the placenta, several pints of lymph were discharged.

Burns, 1822, page 238, says that the discharges of watery fluid from the vagina are not infrequent, and generally depend upon the secretion of glands about the cervix; the rupture of lymphatics, or from fluid collected between the chorion and amnion, or water from blighted ovum in the case of twins.

Dr. Pentland relates a case where coughing produced a discharge, the water being discharged at the fourth month; but labor only occurred at full term.

Merriman, in his work entitled "Difficult Parturition," 1826, relates the case of a lady—six months pregnant—from whom a profuse, watery discharge occurred. She summoned a physician, who assured her that if pains came on she would soon be delivered. She continued, however, to the end of pregnancy, having a profuse discharge each day. At full term she was delivered, her attending physician rupturing a bag of waters, which appeared in no way different from usual cases. No opening was discoverable in either the placenta or the membranes, and he concluded that the discharge must have come from the outside of the membranes.

Chailly, edited by Bedford, 1844, gives a rather full account of hydrorrhœa, the description not being different from those I have already related. He says, however, that these discharges are more

frequent than are generally supposed, but makes the erroneous statement that in nearly all these cases pregnancy is carried along to its full term.

Nearly all modern authors devote a short section to the consideration of this subject, giving different names, as their ideas of its origin and pathology are different.

Three separate pathological conditions seem to be, in many cases, confounded, and I see no way by which a differentiation can be made.

1st. A discharge of the *liqour amnii*.

2d. Discharges from increased glandular action.

3d. A possible collection of fluid between or outside of the membranes, and its irregular evacuation.

In my teachings I have been in the habit of speaking of hydrorrhœa, but never, up to a few months ago, had I seen a marked case. A study of this case with others collected from my own experience, and the perusal of the article written by Dr. Thomas C. Smith, of Washington, D. C., which appeared in the *American Journal of Obstetrics* in May, has caused me to go over the subject carefully and to present what I can obtain from the authorities in regard to these peculiar discharges.

Great numbers of cases have been recorded, but no one, up to this time, has demonstrated conclusively the source of the flow.

The etiology of these discharges has been the subject of very different opinions by different obstetric authors. Chailly says that authors have attempted to show that these discharges are due to the accumulation of fluid between chorion and amnion; to rupture of lymphatic vessels; to transudation through amniotic membranes; to rupture of the membranes at some remote point from the orifice of the uterus, and finally to dropsy of the womb.

Lusk says the pathological processes involved in the disease are vascularity, hyperæmia and hypertrophy of the interstitial connective-tissue, and of the glandular elements of the decidua.

Barnes, in the "System of Obstetric Medicine and Surgery," 1885, says in regard to these discharges, without entering into a critical discussion of the several theories, that it seems to be well established that there are five sources from which this fluid may come:

1st. A discharge from the cervical canal.

2d. The decidual origin.

3d. Transudation through the amniotic membranes.

4th. Hydatidiform degeneration of the ovum.

5th. Cauliflower excrescences.

The *Differential Diagnosis* must rest between the following similar discharges:

I. From the discharge from hypertrophied cervical glands.

II. Fluid collecting between chorion and amnion, occurring only once.

III. Escape of fluid from amniotic cavity.

I. The fluid escaping from the hypertrophied glands must be small in quantity, and we would expect that it would continue for a considerable length of time. There would be no diminution in in the amount of *liquor amnii* and the child would be found floating in the usual amount of fluid.

II. If the fluid collected between any of the membranes, and adhesive inflammation surrounded it followed, a considerable amount of fluid might collect, and the discharges would be considerable at once, and might or might not be repeated. In such a case there might be a lessened size of the abdomen.

III. Where the *liquor amnii* escapes there would be a greater tendency to uterine contractions; a more perceptible diminution in the size of uterine tumor, and a microscopical or chemical examination would certainly reveal some evidence of urine, as we know this exists in variable quantities in the *liquor amnii*.

Transudation through the amniotic membrane, although recently noticed by Barnes, and mentioned by older authors, would give rise to the discharge of a very small amount of fluid.

This could hardly be differentiated from a slight discharge taking place from the cervical glands. Fluid discharges from hydatidiform degeneration of the chorion or from cauliflower excrescence, would be

associated with the diseases which cause them that the diagnosis would not be difficult.

Prognosis.—As far as my observation goes, the life of the woman is not jeopardized, but she suffers from the constant discharge and becomes anæmic. The pain is sometimes severe, as I have before remarked, and the patient is full of gloomy forebodings and anxious in regard to the final results.

The fœtus is usually born prematurely, and, in many cases, only lives a short time.

The treatment must necessarily be very simple—rest and anodynes being about all that can be suggested.

Society Reports.

TRANSACTIONS OF THE CHICAGO GYNÆCOLOGICAL SOCIETY.

STATED MEETING HELD JANUARY 15, 1886.

The President, DANIEL T. NELSON, M.D., in the chair.

Dr. Charles Warrington Earle read a paper entitled,

THE WATERY DISCHARGES OF PREGNANT WOMEN.*

DICUSSION.

Dr. H. P. Merriman: Mr. President, I had one case of this kind about a year ago. The woman had a sudden gush of water when she was not quite five months pregnant. I thought it might presage labor, and told her to let me know of any symptoms of labor—that I expected it would come on. But she felt better after having had the gush of water. She had, in the course of two or three weeks, another, and said she could not tell when they were coming on, because she felt so full before they came. When the second came I began to think that perhaps she was not going to have labor at the present time after all; that it probably was not a loss of the amnoitic fluid, and I examined her and found the os not dilated. I could feel, however, by carefully introducing my finger, that there was water still remaining there, the amniotic bag remaining apparently intact. I gave her opiates, thinking that labor might possible be prevented. She went along for nearly a month after that, before she finally miscarried. She had three separate gushes of water at intervals of two or three weeks before her miscarriage finally came on. The fœtus had perhaps a little over six months of intra-uterine life at the time of its expulsion.

It strikes me that we might learn by careful examination of the placenta and membranes after delivery, a great deal more than we have learned about this subject. I cannot help thinking that there must be some defect in the fœtal envelopes to have a thing like this occur. It could not have been a rupture of the amnion and chorion, as I have seen in one other case in my own practice in which the infant or fœtus enveloped in the amnion came away, leaving the chorion within the uterine cavity. And we had a similar case presented to the Society a year ago, by Dr. Sawyer. The amnion had been separated from the chorion and came away intact by an effusion of liquid between the chorion and amnion. Now, if that takes place, why of course there may be a separation in part and then adhesion again after the occurrence of the rupture. Any gush of this kind indicates, to me at least, some disturbance of the fœtal envelopes, either of the chorion or amnion, or a cystic degeneration of the placenta; and it strikes me that in every case of this kind the placenta and membranes ought to be carefully observed after the delivery, to see what pathological cause brought on the abortion.

I would like to state, in addition to my case, that the woman finally had her miscarriage quite suddenly. I was not present, and another physician was called.

The Chairman: I would like to ask a question as to whether there is any specific cause operative in the production of these cases? Whether syphilitic or gonorrhœal infection may have anything to do with it, and also whether in-

*See page 378.

flammation of the mucous membrane of the uterus precedes these causes? Is it, in other words, an acute or chronic inflammation of the mucous membrane that causes it?

Dr. Henry T. Byford: I have nothing to add, except that Dr. C. R. Parke, of Illinois, reported a case to me, in which the discharge of the *liquor amnii* took place, labor pains came on, and the umbilical cord became prolapsed. He replaced the cord and gave ergot. As labor did not progress, he finally gave morphia and quieted the pains. In three months the woman was delivered of a living child; mother and child did well.

Dr. H. P. Newman: I saw a single case, the discharge however, was greater than in the cases related, and came on about six weeks previous to the abortion; the membranes were not examined.

Dr. W. W. Jaggard said that he had listened to the reading of Dr. Earle's paper and the discussion with great interest. He could not, however, agree with the author of the paper in considering the pathology of *hydrorrhœa uteri gravidi* as obscure and confused in all its details. Carl Braun (*Zeitschr. d. Ges. d. Wiener Aerzte*, 1858, *No.* 17, *p.* 257) and C. Hennig (*Der Katarrh der innerea weiblichen Geschlechtstheile, Leipz.*, 1862, *p.* 48) had clearly and distinctly described the pathological anatomy of the condition. Chronic decidual endometritis may terminate in the formation of new connective tissue, or may manifest itself by the production of a yellow, sero-albuminous fluid, variable in quantity, which accumulates between *decidua vera* and *reflexa*, or when *vera* and *reflexa* are united, between decidua and chorion. Carl Braun accordingly considers the condition to be a *serous endometritis*. Hennig aptly terms it *catarrhal decidual endometritis*. Catarrhal decidual endometritis must be distinguished from collections of fluid between the amnion and chorion, the so-called amnio-chorial water. Bischoff has designated the unorganized, albuminous fluid uniting chorion and amnion as the *tunica medica*. The quantity of this fluid may increase abnormally, at the same time that its consistency is diminished. McClintock describes a case, referred to by Spiegelberg, in which the amount of "amnio-chorial water" was so great as to simulate hydramnios. The "amnio-chorial water" may be discharged without the interruption of pregnancy, but then the discharge of fluid is not repeated as in the intermittent discharges of *hydrorrhœa uteri gravidi*. Labor always follows the rupture of the amniotic sac, a fact which establishes the possibility of a differential diagnosis in the large majority of cases. It is unusual for labor to be prematurely induced by the discharge of the "amnio-chorial water," or collections of catarrhal secretions between chorion and decidua.

A condition strictly analogous to *hydrorrhœa uteri gravidi* is frequently observed in uterine fibroids. The intermittent discharge of a yellowish sero-albuminous fluid from the uterine cavity is a symptom of such frequent occurrence in this condition that attention is directed to it by most systematic writers.

With reference to the ætiology of *hydrorrhœa uteri gravidi*, there were several facts of practical import. Any antecedent endometritis,—gonorrhœal, syphilitic or of other origin,—is an adequate factor. Hydræmia appears to favor the development of the condition. The coincidence of hydræmia with catarrhal decidual endometritis would certainly indicate the exhibition of chalybeate tonics in the treatment of the latter affection.

He fully agreed with Dr. Merriman in attaching great importance to the critical examination of the fœtal envelopes in order to clear up a doubtful diagnosis.

Dr. Edward Warren Sawyer called attention to the fact that watery discharges from the uterine cavity frequently occurred during the *puerperium*.

He thought that the condition, technically termed *hydrorrhœa gravidarum*, was due in all cases to the transudation of the amniotic fluid. This was the opinion ably advocated by Charpentier.

Dr. W. W. Jaggard thought Dr. Sawyer had not quoted Charpentier correctly. Charpentier mentions Stapfer's

recent monograph (*Thèse de concours*, 1880), in flattering terms; enumerates the various hypotheses proposed by a large number of observers, and says the German theory, already referred to, is the most probable.

Dr. Charles Warrington Earle.—I have but very little to say, Mr. Chairman, in closing the discussion. It seems to me, however, that there is one thing, at least, that we should learn from our consideration of this subject this evening. It seems to be impossible for any one to determine the exact source from which a considerable amount of fluid is occasionally discharged from the vagina of a pregnant woman. We do not know whether this fluid comes from the amniotic cavity or external to it; therefore, we should not give ergot or commence the dilation of the *os uteri* after a watery discharge, believing that labor must come on, because from the testimony we have received here to-night, and from other evidence, it does seem that even if the *liquor amnii* is prematurely evacuated in a few cases, pregnancy may go on to full term.

My attention has been called to the phenomenon mentioned by Dr. Sawyer, and if I had not desired to make my paper as brief as possible, I should have spoken of the watery discharges which occasionally take place after labor. I have never seen a case, but it is mentioned in the literature, and it is believed by those who have written upon the subject that the fluid in these cases comes from either the large lympathic vessels, or perhaps from a continuation of the same disease which produced the discharge before. The Doctor is certainly not quite in accord with the majority of authorities when he says that the discharges of pregnancy always come from the cavity of the amnion.

Dr. Edward Warren Sawyer: No; but the term "hydrorrhœa" should be reserved for that class of cases.

Dr. Earle: This is not hydrorrhœa, as I understand it. This term should be applied to a discharge of fluid from outside of the amniotic membrane; perhaps not from outside of the chorion, but certainly from outside of the amnion.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD FEB. 22, 1886.

The President, Dr. W. F. A. Kemp, in the chair, J. M. Hundley, M.D., Secretary.

A CASE OF CEREBRO-SPINAL SYPHILIS, WITH EXHIBITION OF PATIENT.

Dr. J. W. Chambers exhibited a case of cerebro-spinal syphilis. The patient is a white man, 29 years of age, who contracted syphilis five years ago. He had the usual symptoms consecutive to the initial lesion. He now has a perforation of the hard palate, scars in the throat and on the forehead; decidedly increased patellar tendon reflex; skin reflexes generally, decidedly increased; gait ataxic, but not the decided throwing of the foot characteristic of locomotor ataxia; sensation generally good, which excludes any gross lesion of the spinal cord. He had pains in the head and tibia. Are these symptoms due to gummata of membranes of the brain? He has had strabismus which may be due to gummata, but he thinks the other symptoms are rather due to trouble with the arteries at the base of the brain, *an arteritis*. The symptom referable to the spinal cord, is due to an anæmia of the cord, which anæmia is induced not so much by an arteritis as from the anatomical arrangement of the arteries in it lower part.

Treatment—It is not fair, Dr. Chambers thought, when one was treated for syphilis and did not get well, to say he had not the disease. When the function of a part is destroyed it cannot be reproduced, and syphilis often did that, producing changes which could never be repaired. In the treatment of syphilis of the nervous centers the remedies are to be used in very large doses, and it is erroneous to think that mercury is of no use in the tertiary stage. The so-called mixed treatment is by far the best and must be given in large doses. In the treatment of this case cod liver oil and the hypophosphites were used in ad-

dition to the anti-syphilitic remedies.

DISCUSSION.

Dr. John Morris asked how long the man had been under treatment.

Dr. George H. Rohé said the case came under his charge at *Bay View* in last September. At that time the cerebral symptoms were not fully developed and there were no spinal symptoms. The man might have been cured at that time if he could have been induced to take the medicine, but he refused positively to continue after taking a few doses and left the hospital, and he saw him no more till he came under Dr. Chambers' care.

Dr. Chambers said he had been treating him since the 19th of last December, and he had somewhat improved, though did not think he would ever be cured.

Dr. J. D. Blake thought the case very interesting, and its two most prominent features were the want of coördination and the slowness in answering questions. He attributed the first to involvement of the corpus collosum and the second, probably, to the cerbellum. As the patient is improving, he thought continued large doses of iodide of potash might cure him.

Dr. R. H. P. Ellis was often struck with the infrequency of serious trouble, as in this case, after syphilis—why some get well, or seemingly do, and others with the best of treatment fare so badly he is unable to comprehend.

Dr. J. M. Hundley related a case of

HEMORRHAGE OCCURRING THIRTEEN DAYS AFTER DELIVERY.*

DISCUSSION.

Dr. Henry F. Hill agreed with Dr. Hundley in believing that the ergot kept up the tonic uterine contractions, and thought if it had not been given so early, the cervix could have been dilated with the fingers as was attempted. He uses ergot in every case of labor, especially for the first six days after confinement; he believes in using it thus; it keeps the uterus always contracted upon itself, leaving no space for the accumulation of fluids, which if long retained decompose and give rise to septicæmia,

Dr. A. Atkinson said, the rigidity of the cervix might or might not be due to the ergot. He had quite frequently seen cases behave just as this one, and no ergot had been used. He related a case in which there was adherent placenta and the cervix so unyielding he used chlorotorm, which did no good and only succeeded after giving tartar emetic.

Dr. Jno. D. Blake said he would not leave a patient knowing there remained a small bit of placenta. As to the giving of ergot he believed it to be only a habit and a bad one. He used to give it in every case, simply because he thought it the thing to do; he had some time since abondoned it and had not given but ʒj in two years; even in a case of *triplets* where there must be much bare uterine surface, he did not use it. He did not wish to produce the impression that he would not use it when it was required.

Dr. T. A. Ashby said that he wished to congratulate Dr. Hundley on the careful and accurate report given of this interesting and instructive case. There are several facts in connection with the treatment of the case which were worthy of consideration. Dr. Hundley had indicated the line of discussion by the questions enumerated in closing his report. The use of ergot in labor is one of those problems about which there seems to be an unnecessary amount of ignorance and misunderstanding upon the part of many practitioners of obstetrics. No one can question the value of ergot in obstetric practice when judiciously used, but the speaker was prepared to endorse the statement of Dr. Blake, to the effect that ergot was administed far too frequently and too carelessly. It is given in haphazard way by many practitioners, on the assumption that it can do no harm and may do much good in hastening the progress of labor. The wonder is that more accidents do not occur from its use than are reported.

*See page 377.

It is very true that many patients bear ergot well and no seeming harm results from its injudicious administration, but this is no argument in favor of the habit of administering the drug indiscriminately or in a routine way. The rule to be observed is not to use ergot unless there are indications calling for its employment, and then it should be given in a guarded way and in deference to the physiological action it may invoke.

Dr. Ashby said that he did not intend his remarks as a criticism upon Dr. Hundley's treatment of his case. It is quite easy to criticise the treatment of a case from a theoretical standpoint, but this is not the way to deal with facts. In the clinical study of a case our practice must be influenced more or less by the circumstances and indications which are met with at the time, and we are often under the necessity of adopting a line of conduct which does not meet our full approval and which may be at fault in theory. The result in Dr. Hundley's case had been eminently successful, and Dr. H. had no doubt treated the conditions as they were presented to him to the very best advantage under the existing circumstances.

Referring to the second point made by Dr. Hundley in reference to the immediate removal of the retained placenta, Dr. Ashby said that he considered it to be the first duty of the obstetrician, after the delivery of the child, to see that the after-birth is removed and that the uterus is firmly contracted. As a rule of practice he does not consider it safe to leave any portion of the placenta in the uterus, but there are exceptions to all rules. Practically speaking shreads of placental tissue are frequently left in the uterus and they may do no harm, still the risk involved is not a light one. The pitcher never goes to the well too often without being broken, and so, in these cases, septicæmia may be the exceptional result, but the loss of a single patient is enough to condemn the method of practice. Opinion is greatly divided in regard to the management of retained placenta after child-birth or abortions. There are eminent authorities who advocate leaving the placenta in the uterus until it separates, or until the indications calling for its prompt removal are present. On the other hand equally eminent authority says: dilate the cervix and scrape off the plancental tissue without delay. Between these two opposing methods a line might be drawn in favor of the conservative plan of frequently irrigating the uterus with hot water antiseptic injections and hourly watching for the condition which would suggest an attempt at removal.

Dr. Ashby did not think the operation of dilating the cervix and curetting the uterus a difficult, or serious, procedure if it was intelligently done. With the large bi-valve dilator of Sims or Ellinger the cervix can be divulsed so as to admit a curette, or even the finger. The mucous membrane should be carefully scraped and all placental tissue removed. The result is usually very satisfactory, though metritis or cellulitis may be set up if the patient is not carefully treated. He had witnessed one obstinate case of pelvic cellulitis, the result of a slight curetting of the uterus for fungous growths, which was induced by the patient getting out of bed too soon after the operation. The advantage of the operation for the immediate removal of the placenta is strengthened by the fact that when the placenta is allowed to remain for any great length of time it not infrequently happens that firm union takes place between the uterine mucous membrane and the placental mass, by which it becomes incorporated into a growth or vegetation, which is very vascular in character and is sure to lead to menorrhagia. This is especially true if the placental tissue is left after an abortion. Here the separation between the uterine mucous membrane and the placenta is less favored by fatty degeneration, and vegetations are almost sure to follow. Dr. Ashby has witnessed this condition of affairs in no small number of cases. He recalled at the moment three cases which had lately come under his observation where menorrhagia was due to early abortions, probably at about the sixth week. In these cases the uterine mucous membrane had been left in a rough and granular

condition by the want of proper separation of the decidual membrane after the abortion. He believed that a number of uterine troubles could be referred to early abortions, those taking place from four to eight weeks after conception. The moment conception takes place the uterus is prepared in a physiological way for the new function. It begins to enlarge and in one month or six weeks has been considerably modified by the new growth of tissue. At this time menstruation may return, and, except from the free loss of blood—an excessive menstruation — the patient may not have a suspicion of an abortion. She continues her usual duties without realizing the condition of her uterus at the time, but subsequently the organ remains enlarged, congested and weighted down in the pelvis. Hemorrhage is excessive and prolonged at the next period; backache, leucorrhœa and other disturbances of the generative function announce a condition, the cause of which can only be explained when the history of the case is related. These histories read, regular periods, then a missed period with subsequent periods characterized by a very free loss of blood. The subsequent symptoms appear as related. This digression does not bear upon the points under discussion in Dr. Hundley's paper, but it is intended to emphasize the value of the curette as a means of removing abnormal villosities and vegetations from the uterus whether these conditions result after abortions, miscarriages, or child-birth.

To sum up the treatment of retained placenta, Dr. Ashby said, in conclusion, that in his opinion it was far safer to remove the placenta at the time of delivery of the child, even if it was necessary to dilate the cervix in order to do so. If the retained masses of placenta or decidual tissue were left after abortions, he considered it eminently advisable to dilate the cervix and scrape out the uterine cavity with the curette at the earliest practical moment. He did not pretend to say that in all cases of retained placenta trouble would follow, but he claims that the risk involved in leaving the mass behind is greater than the operation required for its removal, unless performed in the most unskillful and unintelligent manner

Dr. B. S. Roseberry said this case shows that the adherent piece of placenta should have been removed. As to delivery of the placenta, he never hesitates to introduce his hand into the uterus and take it away as soon after delivery as possible, and he has never had any unfavorable symptoms from so doing. He usually gives a full dose of ergot after removal of the placenta.

Dr. A. Atkinson said he had known an entire placenta to remain in the uterus for several days without giving rise to septicæmia.

Dr. R. H. P. Ellis said under no circumstances should a piece of placenta be allowed to remain, and he would hesitate to leave a patient of his knowing such a state existed. He gives ergot always, but only after the uterus is empty; believes the ergot, in keeping the uterus in a state of tonic contraction, prevents to some extent septic infection. The placenta should be delivered as soon as possible after birth of child, and by the method of expression, though he would not hesitate to introduce his hand into the uterus when necessary.

Dr. J. L. Ingle said he seldom used ergot, and in fifteen or twenty minutes, if placenta is not within the vagina, he introduces his hand and takes it away.

Dr. J. W. Chambers said he saw no use in giving ergot unless it was needed; he, however, thought it a good plan to give small doses after labor to assist the uterus in returning to its normal size. The ergot acted as a uterine tonic assisting involution.

The President said he would have acted in the case just as Dr. Hundley had done. It is far from easy to get away every particle of placenta when adherent, and it is wiser to take away what we readily can, than to to make too protracted efforts at complete detachment.

Dr. T. A. Ashby asked permission to supplement the remarks made at the beginning of this discussion by an additional statement in reference to the use of ergot. Many of the members of the

Association, he said, would doubtless recall the famous aphorism of Beaudelocque to this effect, that the obstetrical forceps had been more injurious than useful to society. No one could question the value of the forceps, but Beaudelocque made this assertion in view of the fact that the instrument was too frequently, too injudiciously, and too ignorantly employed.

The same line of reasoning would apply to ergot. The value of this drug should not be questioned, but in view of its injudicious use it has probably done far more harm than good. Many physicians seem to lose sight of the fact that labor is a physiological function and that it can be performed without the meddling instrumentality of the midwife or obstetrician. The habit of giving ergot without reason, is a serious fault and should be condemned. There are certain indications which call for its use and unless these are present it should not be employed. The drug is of great value in its proper place, but it should no more be given indiscriminately or without regard to its physiological action than strychnia, opium, belladonna or any of the narcotic poisons. We should be careful how we interfere with a physiological function in administering therapeutic agents.

WAXHAM: TREATMENT OF CROUP. (*Chicago Medical Journal and Examiner*, June, 1885.)—In the treatment of this disease the author approves of trypsin as one of the most, it not the most, valuable agents for dissolving the false membrane. His formula is,

℞—Fairchild's ext. pancreatis, gr. xv;
Sodæ bicarb. gr. iij;
Aquæ dist.,
Glycerinæ, āāʒss.

The mixture may be used with an atomizer, and great pains must be taken that the spray may reach the affected parts. Lime water is mentioned as an excellent solvent, but only when the membrane is immersed in it. The vapor from a boiling solution does not dissolve it, as was shown by exposing a large fragment of false membrane to the vapor constantly for three hours. In the given experiment the membrane was neither disintegrated nor softened. The author admits, however, that benefit may be derived from the heat and moisture of the of the vapor. The same piece of membrane which was exposed to the vapor was placed in a two ounce phial which contained an officinal solution of lime water; in seven minutes it had been completely dissolved. Another piece of membrane was subjected to a spray from a hand atomizer which contained the pancreatin solution according to the formula already given. It was sprayed four times at intervals of half an hour, and at the end of that time the membrane was disintegrated. Again, a similar piece of membrane was sprayed with officinal lime water every half hour and was dissolved after six applications. A spray of a ten per cent. solution of lactic acid softened the membrane in three hours and a half, being used, as in other cases, at intervals of half an hour. The membrane was not completely disintegrated however. The conclusions which were reached were: (1.) A solution of pancreatin with soda and glycerine, furnishes the most satisfactory solvent. (2.) The spray of lime water will dissolve false membrane, but not so efficiently as the pancreatin. (3.) The vapor from boiling lime water is of no use as a solvent (4.) Lactic acid is not a good solvent.

O'Dwyer's method of tubing the larynx in croup receives unqualified praise. Its advantages are: (1.) The tube can be introduced and without danger. (2.) There is no mutilation. (3.) No wound as a cause of shock, or source of infection. (4.) The tube can be worn more easily than a tracheotomy tube, and without greater hinderance to coughing and expectoration. (5.) It does not require constant attention as does a tracheotomy tube. (6.) Bronchitis and pneumonia are less likely to occur than when tracheotomy has been performed, the respired air being warmed on its way through the natural air passage. (7.) The operation is less likely to be objectionable to the parents.—*Archives of Pediatrics.*

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BALTIMORE, MARCH 13, 1886.

Editorial.

DR. FORDYCE BARKER ON THE VALUE OF PERMANGANATE OF POTASH IN THE TREATMENT OF AMENORRHŒA.—It has been some five years since Drs. Ringer and Merrell first called the attention of the profession to the value of manganese in the treatment of amenorrhœa, and other disturbances of the uterine function. Since this announcement was made this drug has been employed by a number of careful observers in the treatment of the conditions mentioned, and the reports which have been published have tended to confirm the favorable opinion expressed by Drs. Ringer and Merrell. The drug has undoubtedly disappointed some practitioners who have used it, and adverse reports have been a natural result of its indiscriminate employment. There are certain conditions of the generative function in which amenorrhœa is but a natural result, conditions in which manganese is as likely to fail in its duty as any other of the numerous so-called emmenagogues which are employed. Every one who has had a large experience with those articles of the materia medica which are classed as emmenagogues must have realized the fact that in certain cases these agents will fail, and the uterine function will remain uninfluenced by their action. It is, perhaps, in this class of cases that manganese will be found of little value in establishing the periodic flow of blood from the uterus. There can be but little doubt, however, of the fact that manganese is almost specific in its action in overcoming amenorrhœa in a large number of cases. Proof of this assertion will appear when the literature of this subject is carefully studied. We have before us a very valuable contribution to this subject from the pen of Dr. Fordyce Barker, of New York, (*N. Y. Med. Jl.*, Feb. 27, 1886,) in which an experience is related which greatly strengthens this statement. Dr. Barker has used the permanganate of potash almost exclusively, when an emmenagogue was indicated, for the past four years. The class of cases in which he has employed it are arranged in the following groups:

"*First.*—Young ladies between the ages of fourteen and nineteen, who come from the country 'to finish their education.' Home-sickness, entire change of their habits of life and associations, overtax of their brain power from their own or their teachers' ambition to accomplish more in a given time than they ought to attempt, not infrequently lead to an arrest of menstruation. I see at least ten or fifteen such patients every winter.

Second.—Ladies, both young and married, who suffer severely from seasickness, that have left some European port within a few days of the menstrual period. With such, amenorrhœa, of longer or shorter duration, is almost sure to follow. I am consulted by at least eight or ten such every year.

Third.—Ladies between thirty and forty, generally married, some of whom have borne children, who rapidly begin to gain flesh, grow stout, while at the same time menstruation decreases in both duration and quantity, until at last it is only a mere pretense. This is generally attended with annoying nerve-disturbances, pelvic weight, sometimes hæmorrhoids, and often mental depression from the apprehension of growing old prematurely."

Dr. Barker now avows that never, where in either of these classes of cases that he has prescribed the permanganate, has he *known* it to fail. In prescribing the permanganate he directs the patients to continue the use of the medicine, if necessary, for at least three months, and

he especially urges them to report to him either personally, or by letter, if the end is not accomplished. With this specific treatment, Dr. Barker, has, however, not neglected any other measures necessary to keep up a healthy and regular action of other functions. He is also careful never to prescribe the permanganate in cases where the amenorrhœa is due to some grave constitutional disease, nor does he rely on it for the relief of sudden suppression due to cold, moral shock, or an acute disease.

Dr. Barker has experienced the same difficulties in administering the permanganate as have been reported by others who have prescribed the drug. It is well-known that the permanganate undergoes rapid decomposition, and that it will produce in most persons severe gastric pains. Indeed it is taken with great repugnance as a rule. To overcome the peculiar taste and unpleasant effects of the drug Dr. Barker has adopted the plan of giving it in two grain tablets and immediately thereafter administering a half-tumbler of water, not cold. He usually prescribes two grains three times a day. Dr. Barker gives, as the result of his clinical experience with the permanganate of potash, a report of forty-three cases of amenorrhœa, of the groups mentioned, and at the time of writing he is not able to recall an instance where he made a domicile visit for this disease.

It is well-known that Dr. Barker is an exceedingly careful observer and accurate reporter. His experience with the permanganate in amenorrhœa speaks volumes in favor of its judicious employment in the groups of cases in which he has obtained his results.

Hégar's Sign of Early Pregnancy.—There are few physicians who have not been consulted by anxious patients during the early weeks of pregnancy, who wished to ascertain the correctness of their fears, desires or imaginations respecting their condition, and every well-informed practitioner knows how utterly difficult, if not impossible, it is to make a diagnosis of pregnancy during the early weeks of gestation. It is true, there are numerous signs, but to interpret them correctly is not a light task, nor is it an easy duty. The necessity of a positive assurance of the non-existence of pregnancy is frequently experienced by the gynecologist. Cases present themselves for treatment where this doubt must arise and where local treatment must be held in abeyance until the doubt is solved. He must be a gynecologist of limited experience, or a poor student of human nature, who has not now and then observed upon the part of a few crafty females a certain desire for local treatment when suspicions pointed to a possible conception. It is a happy circumstance that such occurrences are extremely rare, but we believe the incautious and non-suspecting practitioner may now and then be led into a grave error of practice if his eyes are not keenly open to this fact. In the absence of a positive assurance of the non-existence of pregnancy the sole course open is to defer local treatment until the doubt can be solved. This may lead to much unnecessary delay and to unpleasant embarrassments, but it is the only safe rule of action. The question arises: Can the diagnosis of pregnancy be established with certainty as early, even, as the fifth week of utero-gestation? In our opinion it can not; but there are observers who differ with us. For example Hégar offers a sign which he claims is present as early as the fourth week. Quite recently Dr. E. H. Grandin of New York (*N. Y. Med. Record*, Feb. 27th,) has asserted that he had frequent opportunity of putting Hégar's sign to the test, and that he has by means of it, been able to assert as early as the fourth to the sixth week that gestation existed. In order to make Dr. Grandin's experience show to the best advantage we quote his language:

"Since my object is to call attention to this sign of Hégar's, and not to rehearse the signs which, in the early months of pregnancy, point to this condition, I proceed at once to its consideration; and, in order to make the sign clear, would call attention to the gross changes which take place in the uterus prior to the second month of uterine gestation: that is to say, before any classical physical sign—such as discoloration of the vaginal mu-

cous membrane, softening of the cervix—have become at all marked. The early rational history I purposely leave out of the question, for such history our patients frequently falsify."

"During the first six to eight weeks of pregnancy the changes in the uterus are practically limited to the body of the organ. The uterine body enlarges, especially in its transverse diameter (antero-posteriorly); the muscular substance becomes less dense. These changes are simply the result of the hyperæmic condition into which the corpus is thrown and kept by the engrafting of the impregnated ovum. As the result of such changes, the uterine body loses its nulliparous pear-shape; its contour no longer gradually diminishes as it approaches the uterine neck; the body, on the contrary, bellies out (if I may use the term) over the cervix in all the transverse diameters, in particular, antero-posteriorly, and the organ, instead of being pear-shaped, resembles very much an old-fashioned, fat-bellied jug."

"The above changes in the consistency and shape of the body of the uterus constitute Hégar's sign, and so far in at least a dozen cases, it has never failed me in early diagnosis. The obtaining of this sign requires of course, a certain expertness in the bi-manual palpation, and familiarity with the sensation communicated to the finger by the nulliparous uterus, and the uterus altered pathologically in one or another way. I have found, however, in my clinical teaching, but little difficulty in making even inexpert fingers conscious of the change. In the vast majority of cases, owing to the normally slight anterior curvature of the uterus, the internal examining finger will note this sign to the best advantage in the anterior cul-de-sac. Here the finger, instead of following the line of the cervix in a gentle curve up on to the body, is at once conscious of the body swelling out to a greater or lesser degree, according to the date of impregnation, over the cervix, and at the same time, bi-manually, the body is faintly boggy, resilient, compressible. If such be the condition of affairs detected by the local examination, in the absence of rational history, in the absence of slight softening at the tip of the cervix (which may, if present, mean erosion), and of mammary signs and blue discoloration of the vagina (both of which, if present, may mean ovarian disease), I now unhesitatingly pronounce the patient pregnant."

Dr. Grandin points out the conditions which may possibly simulate Hégar's sign; first, a distended bladder, and, second, a uterus distended with menstrual blood. Neither of these conditions, however, he says, ought to give rise to error, for a necessary prelude is a careful bi-manual evacuation of the bladder by means of the catheter, and retained menstrual blood would necessarily be suggested by the history.

Hyperplasia of the corpus uterus, subinvolution and the varieties of displacement, he claims, may be determined by the compressibility, resiliency and other changes in the uterus which are incident to these special conditions.

Dr. Grandin seems to have had remarkable success in testing this sign of Hégar. In eleven cases in which an early diagnosis was made by this sign, the correctness of the diagnosis was established by after-observation. We regret to say, however, Dr. Grandin has not stated the fact as to whether he had met with a failure in any case in which the test was employed. He tells us very frankly "In order to settle the value of this sign positively, it is of course apparent that others must note the result of their experience. As the matter now stands, Hégar believes this sign to be of great value, Compes regards it as positive and I am inclined, from a limited experience, to consider it infallible."

The Fate of the Proposed Medical Bill.—We published a few weeks ago a bill, which it was proposed to ask the General Assembly to pass, regulating the practice of medicine in this State. The publication was made by request of the Medical and Chirurgical Faculty of the State, and the bill emanated from a committee of that body, which had been appointed for the purpose of formulating a law regulating the practice of medi-

cine. The Faculty was regularly convened by request of the committee for the purpose of considering the measure proposed. The original draft as presented by the committee was amended and otherwise moulded into a shape agreeable to the Faculty. Finally the bill as a whole was approved of, its publication ordered and the committee requested to present it to the State Legislature for action. The main point in the bill which created dissatisfaction was the constitution of the board, which was to consist of five members of the Medical and Chirurgical Faculty and two of the Homœopathic Institute. This dissatisfaction culminated in the calling of a special meeting of the Faculty for the purpose of "reconsidering" the action of the Faculty. The Faculty met on Friday, February 26th,—the bill having in the mean time gone to the legislature—and after free discussion, all of which was opposed to the above mentioned clause, the vote was taken and a motion to "withdraw the approbation of the Faculty from the bill" prevailed. The discussion which was participated in by three ex-presidents of the Faculty and several other prominent and conservative members, showed very plainly the impossibility of the Faculty as such, making any move in favor of Medical Legislation, in which members of the Faculty would be thrown into official or professional contact with Homœopathic or other irregular practitioners, and this we think is tantamount to the conclusion that no action whatsoever is to be expected from that body.

We are profoundly convinced that it will be utterly impossible (even if it were desirable) to procure legislation which would discriminate against the Homœopaths, or which would not allow them a fair representation in the governing body, and until some arrangement which makes this possible can be made we must be content "to bear those ills we have." Those ills can be summed up in very few words. We have no legislative protection whatsoever. The time and expense of a medical education receives no recognition whatsoever from the State. The veriest ignoramus who chooses to call himself "doctor" stands equal before the law with those who have education and experience. Moreover the stringent laws in force in neighboring States squeeze in upon us all the quacks and charlatans which they excrete. In fact we have become a sort of cess-pool into which medical ignorance and knavery naturally gravitate. The bill from which the Faculty withdrew its approval was modelled on the acts which have done so much good in Illinois and West Virginia, and no doubt if passed would have materially improved our condition. It is to be hoped that some other body, which is less afflicted with professional hyperæsthesia, or has a more lively appreciation of the present deplorable state of affairs, will agitate this matter and procure such legislation as the safety of the community and the good of the profession demand.

Miscellany.

Gonorrhœa in the Female.—Dr. Lómer has published in the *Deutsch Med. Wochenschrift*, a contribution entitled "The Significance and Diagnosis of Gonorrhœa in the Female" Professor Bumm has recently asserted that the disease in question chiefly involves the cervix uteri where the ciliated cylindrical epithelium appears to afford it better nourishment than it could receive from the pavement-epithelium of the vagina. Indeed, he looks upon gonorrœal colpitis or vaginitis as a secondary disease, due to irritation of the vagina, through contamination caused by escape of the discharge from the diseased cervix. Neisser's diplococci are said to be pathognomonic of gonorrhœa; but they are difficult to find when mixed up with other organisms in vaginal discharges, nor are they specially affected by any particular staining fluid; besides, diplococci are sometimes found in non-gonorrhœal vaginal secretions, and especially within pus-corpucles. Dr. Lomer has examined the vaginal secretions of several hundred women in Schroeder's wards. He has come to the conclusion that the vaginal secretion is unsuited for the detec-

tion of diplococci in suspected cases; they must be sought in discharges taken direct, with the assistance of a speculum, from the cervical canal. Only those cases where diplococci are found within pus-corpuscles are, in Dr. Lomer's opinion, truly gonorrhœal, but he admits several sources of fallacy, since he has found the same conditions in the vaginitis of children and in women in childbed. Clinical appearances must be taken into consideration, such as inflammation of the vulva, vagina, and urethra. In purulent catarrh of the cervix, Dr. Lomer, like many other authorities, considers that a greenish coloration of the pus is very suspicious. He is able to authenticate previous opinions on the relation of gonorrhœa to sterility, and finds that chronic gonorrhœa is frequently associated with scanty menstruation. The presence of hydro-salpinx or pyosalpinx tends strongly to confirm the suspicion of gonorrhœa. Dr. Lomer found that a very considerable number of the patients whom he examined were subject to gonorrhœa without being aware of it. Whilst the most frequent cause of disease of the uterus and its appendages was the puerperium, gonorrhœal infection came next in order of frequency. Sänger, of Leipzig, found that one-ninth of all the gynæcological cases under his charge were of gonorrhœal origin.—*British Medical Journal.*

Roth: Sulphate of Iron for Catarrh of the Stomach in Little Children. (*Rev. Mens. des. Mal. de l'Enf*, [from *Conseiller Medica*] Sept.)—One of the most important symptoms of this condition consists in the acidity of the contents of the stomach and intestine. The material which is vomited has a sour smell and a greenish appearance. The same is true of the contents of the intestine. The parts which are bathed by these discharges,—namely, the anus, scrotum, vulva, become red. The green discoloration has been attributed to the use of calomel, but that does not apply to cases in which calomel has not been used. Absorbents are indicated to overcome the effects of the acids, and tonics to counteract the cararrh. In cases in which such treatment is inefficacious, the author has used sulphate of iron to good advantage. It acts as a disinfectant, the stools changing color and losing their bad odor. As an astringent, it contracts the turgid mucous membrane, and coagulates albuminoid substances. Its use should be continued several days. The following formula is suggested:

℞—Ferri sulphatis, 0.1 gram;
Mucil. acaciæ;
Syrupi simp., aa 2.00.

Sig., A coffee spoonful every two hours.—*Arctives Pediatrics.*

The Treatment of Painful Fissure of the Anus, Without Operation.—A. D. Macgregor, M.B., C.M., Kirkcaldy, N.B., says in the *British Medical Journal*, February 27th, 1886: In the interesting and instructive lecture on the perineum, by Mr. C. G. Wheelhouse, the operation of "stretching" the sphincter ani is advocated, in preference to "cutting" the muscle. This treatment Mr. Wheelhouse recommends in fissure of the anus, because "we can attain our end without causing an external wound, and thereby rendering our patient liable to septic poisoning." I have hitherto treated these fissures without any operative interference at all, and with such success as to warrant a continuance of the method. The following case will illustrate it.

J. T., a coachman, aged 56, had, for eighteen months, suffered such agonizing pain in defæcation, that an enforced habit of constipation was established. From time to time, he relieved his bowels by enemata, first taking a large dose of laudanum to alleviate his sufferings. On examination with a speculum, I found a fissure, nearly an inch in length, with irregular edges and an indurated base. The sphincter was much hypertrophied, and contracted powerfully and spasmodically during the examination.

I ordered a full dose of castor-oil, with some rhubard for its secondary astringent action, forbidding the customary laudanum. When this operated I had the bowel well washed out with an enema containing Condy's fluid. This done, I passed the speculum, and painted the

fissure with a solution of chloride of zinc (twenty grains to one ounce); then introduced a piece of lint, smeared with boric ointment, the contraction of the sphincter keeping it in contact with the sore. The bowels were kept in check by pilula plumbi et opii. Liquid food was only allowed.

The subsequent treatment consisted in the use of a powder (powdered boric acid, half-a-drachm; violet powder, one ounce), which was sprinkled freely on lint, and introduced into the anus to dry up and discharge, and the continued use of the boric ointment.

By these means the fissure was entirely healed in six days, and there has been no return of the symptoms.

I have always found one application of chloride of zinc enough; it usually causes some smarting and uneasiness, but nothing more effectually purifies the ulcer, or stimulates the reparative process. The introduction of cucaine robs the operative procedure of one drawback—the necessity of taking an anæsthetic; yet, I may recommend a trial of this treatment, at least in the case of those who have an innate horror of anything approaching "cutting."

The Management of Placenta Previa.—In an excellent paper having this title (*Amer. Jour. of Obstetrics*, March, 1886,) the author, Dr. Malcolm McLean, of New York city, sums up the following conclusions:

First.—In any case avoid the application of all chemical styptics, which only clog the vagina with inert coagula, and do not prevent hemorrhage. At the very first, the patient should be put into a state of absolute rest—body and mind—and a mild opiate is often desirable at this stage to quiet irritation.

Second.—Inasmuch as the dangers from *hemorrhage* are greater than all else to both mother and child, at the earliest moment preparation should be made to *induce* premature labor, and labor being once started, the case should be closely watched to its termination by the accoucheur.

Third.—In primiparæ, and in mothers with rigid tissues, the *vagina* should be well distended, by either the colpeurynter or tampon, as an adjuvant to the cervical dilatation.

Fourth.—In the *majority* of cases generally, and in all cases especially where there is reason to believe that rapid delivery may be required, it is more safe to rely upon the *thorough*, *continuous* hydrostatic pressure of a Barnes' dilator than on pressure by the fetal parts.

Fifth.—Where the implantation is only lateral or partial, and where there is no object of hurrying labor, bipolar version, drawing down a foot, and leaving one thigh to occlude and dilate the os, may be practised according to the method of Braxton Hicks, except in cases where the head presents well at the os, when

Sixth, the membranes should be ruptured, the waters evacuated, and the head encouraged to engage in the cervico-vaginal canal.

Seventh.—In the majority of cases, podalic version is to be preferred to application of the forceps within the os.

Eighth.—In some cases, in the absence of sufficient assistance, or the necessary instruments, the complete vaginal tampon, in part or wholly of cotton, may be applied and left *in situ* until (within a reasonable time) it is dislodged by uterine contractions, and the voluntary efforts of the mother. In case of favorable presentation—occiput or breech—the tampon will not materially obstruct the descent of the child, and in some cases the tampon, placenta, and child will be expelled rapidly and safely without artificial assistance.

Ninth.—The dangers of septic infection by means of the tampon, or India-rubber dilators are so slight, if properly used, as not to be considered as seriously impairing their great value.

Tenth.—Whenever it is possible, dilatation and delivery ought to be *deliberately* accomplished, in order to avoid maternal lacerations.

Finally.—As cases of placenta previa offer special dangers from post-partum hemorrhages, septicemia, etc., the greatest care should be exercised in every detail of operation and nursing to avoid conveying septic material to the system of the mother.

Furunculosis.—In an excellent article which appeared in the *Bulletin de Thérapeutique*, Dr. Guigeot in a masterly way laid down the rational treatment of the furuncular affection. There are, according to him, scarcely ten years that we have had any exact notions on the real nature of the boil. It is a contagious affection which has twice been successfully inoculated (Lannelongue) and which appears to be caused by a vegetable parasite, *torula pyogenica* (Pasteur and Löwenberg). The evolution of this disease is completely modified by the nature of the soil on which it develops. Starting with these etiological propositions, Dr. Guigeot shows how little rational were the therapeutic methods formerly held in honor; early incisions, poultices, simple baths, local bleedings, etc.

Parasiticides must be employed as topical applications; the acid nitrate of mercury and carbolic acid have given good results, but the substance which the author has found by far preferable is the tincture of iodine. A thick application must be made to the whole part affected, encroaching upon the surrounding healthy skin. The layers must be painted one upon another, until there is produced a staining of a dark-brown color. Unless this is done, the treatment may not succeed. You can thus obtain a complete resolution if you make the application early enough; in any case you will always greatly diminish the intensity of the pathological process. You should also paint with tincture of iodine all other cutaneous lesions which may develop in patients suffering from furuncles, for if this precaution is neglected, these may also become furuncular. If the employment of tincture of iodine on the face is objectionable on account of its color, it may be replaced by camphorated alcohol. Finally, if the case is a severe one, we have recourse to the acid nitrate of mercury or to carbolic acid.

The furuncles, after being opened, may be dressed with borated water or borated alcohol. Internally, the author advises the administration of the hyposulphite of soda dissolved in a large quantity of water, as Dr. Bulkley has used it; or the preparations of sulphur, which he considers much more efficacious. He uses habitually Pouillet's powder, of which he gives from twenty to eighty centigrammes per day, either in milk or in pure water.

Ordinarily, it is necessary to continue the medication by sulphur a month at least, and to take it up from time to time in obstinate cases to prevent relapse.—*Jour. of Cutaneous and Venereal Diseases.*

A Case of Protracted Pregnancy.—Dr. Arnold Thompson recently reported to the London Obstetrical Society the following case:—The patient was a delicate woman, not long married, who had had a miscarriage previously, occasioned by a shock. After this, menstruation recurred, and the last period ended June, 1884. Her husband left home a week after, and returned on Monday, June 16th, for one night only, on which coitus took place. He left home the next morning and was away for four months. Soon after the husband's departure signs of pregnancy appeared. Delivery took place April 13th, 1885, 317 days after the end of the last menstruation, or 301 days from the last coitus. The dates were absolutely certain. The child was not weighed or measured; it was a female, and appeared of full average size and weight. According to Prussian law the child would be legitimate; according to Scottish law and the French code, it would be illegitimate; in England its legitimacy would be determined by circumstances. — *Boston Med and Sur. Jl.*

Statue of Claude Bernard—Last Sunday, February 7th, the statue erected in honor of M. Claude Bernard was placed on its pedestal occupying a commanding position in the garden in front of the College de France. Several eloquent and appreciative addresses were made by M. Bert the President of the Subscription Committee; by Professor Chauveau, who represented Lyons, Bernard's birth-place; and by M. Dastre, who represented M. Bernard's most

recent pupils. M. Guillaume is the sculptor. The house in which Bernard lived and died is exactly opposite the standing place of the statute.—*British Medical Journal*, February 13th, 1886.

Five Children at a Birth.—Dr. V. Teyxeira reports in the *Gazetta degli Ospitali* (21st inst.) that a woman in the seventh month of pregnancy was delivered of five living children—two female and three males. Three had died, and two seemed in a hopeless state at the date of report. The mother was progressing fairly.—*London Lancet.*

Antipyrin in Rheumatism and Migraine—Professor M. A. Khomyakoff and Dr. L'voff, writing in the last number of the *Vrach*, highly praise antipyrin both in acute and chronic rheumatism. They prescribe it in from fifteen to twenty grain doses four times a day, and find that in acute rheumatism it very quickly relieves the pain and reduces the swelling without producing any unpleasant effects. It was successful, too, in two cases in which salicylate of soda in large doses had entirely failed to afford relief. Antipyrin proved equally valuable in muscular rheumatism, rheumatic pains in the head and limbs, and in neuralgia of rheumatic origin. It was also employed in twenty-five cases of migraine and pains in the head from various causes. In most of these cases the first dose of from fifteen to twenty grains of antipyrin produced a marked alleviation of the pain within twenty minutes. If no effects were produced, a second dose was administered half an hour after the first, and even in the severest cases this did not fail to relieve. Unfavorable symptoms did not present themselves at all throughout the investigation.—*London Lancet.*

State Board of Examiners—There is a Bill before the Virginia legislature for a "Homœopathic State Board of Examiners" and as there are only fifteen homœopathic practitioners in the State, according to the *Va. Medical Monthly*, it is proposed that the homœopaths appoint a committee to examine in materia medica and therapeutics, such candidates as signify an intention to practice homœopathically. This plan is all right, providing no injustice is done candidates from prejudice. The examination should be conducted by examiners ignorant of this intention, and the election as to materia medica, etc., might be deferred until after all other branches are finished. If the intention is to deal honestly and justly, there will be no difficulty, and the plan proposed will be the simplest. It would be much better if the State Board of Medical Examiners would introduce a series of questions with their own, which would be satisfactory to the homœopathists as well as to themselves, covering the action of drugs, which should be answered by all candidates. All practitioners will admit that a knowledge of the physiological action of drugs is absolutely necessary to the intelligent practice of medicine.

With a reasonable knowledge of the physiological action of drugs, one may practice homœopathically or allopathically, as occasion may require, and the question as to the intention had better never come up.

Let the "regular school" as it is sometimes called, show the right disposition, and it would soon absorb all that is worth absorbing from the others.

On the other hand, let the questionable and doubtful term "homœopathic" disappear as it is fast doing, and with it will go much of the bigotry and intolerance which its existence has engendered.

There are a large number of drugs which are common to the materia medica of all schools, and it could not be otherwise than reasonable to have the questions confined to these.

In practice of medicine, the answers would necessarily cover a wide range and if the "red flag" *homœopathic* were taken in, there would be no prejudice and hence no injustice.

If the dominant body of physicians who can afford it, would only seize the opportunity with suitable overtures, *dishonorable to none*, and deal with it in the light of the Golden Rule, the sects in medicine would soon be of the past.—*N. Y.* (*Homœopathic*) *Med. Times.*

Medical Items.

The Prussian Order of the Red Eagle, third class, has been conferred on Dr. Bergmann, Professor of Surgery in Berlin.

Dr. H. J. Bigelow has resigned his position as surgeon to the Massachusetts General Hospital. He has been made Surgeon Emeritus, with five beds placed at his disposal.

Although the number of physicians in Germany averages 1 to 3,025 inhabitants, their distribution is very uneven. The cities and watering places are especially well supplied. In Bonn there is 1 doctor to 440 inhibitants, in Wiesbaden 1 to 558, in Berlin 1 to 1,063.—*Medical Record.*

M. Pasteur now claims that his inoculation experiments with the virus of hydrophobia have been sufficiently confirmed to remove all doubt as to their prophylactic value. He proposes now to turn his attention to the cultivation of a virus which will prove a prophylactic against diphtheria.

It it stated by the *New York Medical Journal* that the Newark dogs that were bitten by the dog that bit the children that were sent to M. Pasteur, are reported to be in good health. The probability is that the dog which bit these children was not rabid and hence their visit to M. Pasteur was uncalled for and the result non-conclusive.

The Railroads are already beginning to announce reduced rates of fare to St. Louis, to all delegates to the American Medical Association. This will be an excellent opportunity for many physicians, who have not had the opportunity heretofore, to see the West. The arrangements which are being made by the profession in St. Louis, to entertain delegates to the Association, are extensive and very hospitable.

The second session of the French Surgical Congress will be held in Paris from the 18th to the 24th of October, in the present year. The opening meeting will take place in the large theatre of the École de Médecine. The success which attended the first Congress encourages the committee to expect from this second re-union of French surgeons results most favorable to the advance of surgery in that county.

In Russia, medical students are to a very large extent supported and educated by the Government, but a well-defined pledge is exacted of the student to serve in any capacity that may be fixed for a certain number of years after qualification. This pledge is not uncommonly felt to be a burden, and a number of medical men, at present under the obligation of serving the Government, have petitioned to be absolved from it.

Dr. N. S. Davis, the veteran editor of the *Journal of the American Medical Association*, whose illness was referred to in a recent issue of this Journal, has so far recovered from an apopletic attack that he has resumed his editorial duties. Dr. Davis is now over 70 years of age. He writes to the *American Practitioner and News*, "If the good Lord has more useful work for me to do, I shall endeavor to do it." We trust this may be the case, for no one can doubt Dr. Davis' earnestness, enthusiasm and ability in professional labor.

The Sixth Annual Commencement of the Baltimore Medical College was held at the College Building on North Howard Street, on Monday, March 8th, at 12 o'clock. The degree of M.D. was confered upon nine graduates by the Dean, Professor Wm. Lee. Professor C. G. Hill delivered the address to the graduating class, and Rev. J. E. Grammer closed the commencement exercises with remarks appropriate to the occasion. At 8 P. M. a banquet was given to the students of the College, at the Carrollton Hotel, by the Faculty, which was attended by some 30 students and a number of invited guests. The College has built during the past year a commodius Lecture Hall on its property on North Howard Street, and proposes during this year to enlarge the present hospital building on Garden Street. Some thirty-five students attended lectures at the College during the past session.

An Association of Physicians and Pathologists has recently been organized for the benefit of those members of the profession who are specialists in general medicine and pathology. The membership of this Association is limited to one hundred. It is proposed to hold its annual meetings in the month of June, in the city of Washington. A committee consisting of Drs. Francis Minot, of Boston; W. H. Draper, of New York City; Wm. Pepper, of Philadelphia; R. P. Howard, of Montreal; A. L. Loomis, of New York City; W. H. Welch, of Baltimore; F. Delafield, of New York City, and Jas. Tyson, of Philadelphia, has been appointed to notify those gentlemen who were selected as original members of the Association. The Association bids fair to be one of the most useful of the National special organizations working in the interest of scientific progress.

The regular monthly meeting of the Baltimore Gynæcological Society was held at the residence of Dr. F. E. Chatard, Jr., on Tuesday evening, March 9th. By invitation Dr. P. F. Mundé, of New York City, was present and read a paper on "Ovariotomy During Acute and Chronic Peritonitis." At the close of the meeting, the Society was entertained at the residence of Dr. H. P. C. Wilson, on Park Avenue. In addition to the members of the Society there were present at Dr. Wilson's a few invited guests. Several hours were very delightfully spent in social intercourse. The Gynæcological Society has now 18 members. Its meetings continue to grow in interest and value, as can be attested by the fact that its Transactions have appeared during the past month in some eight or ten Medical Journals.

Original Articles.

ENDERMIC MEDICATION.*

BY E. G. WATERS, M.D., OF BALTIMORE.

An observant physician gave me a useful hint in regard to the treatment of erysipelas. He noticed on the person of a patient who had died of this disease that wherever the surface was dinted, particularly about the head, possibly from handling the body after death, that the little cup thus formed was filled, or partly filled, with serum. He concluded instantly that this resulted from overloaded vessels permitting finally their contents to escape through the law of osmosis, now that the vitality of the tissues no longer resisted effectively this law. He asked himself why could not this relief be given earlier, and in this way arrest morbid processes, abscess, gangrene, death, and contribute to speedy restoration of function and recovery. The nature of the morbid process seemed to be obvious. First there was a rapid and violent congestion of the tegumentary tissues, followed by constriction and and strangulation of vessels, always tending to embrace areas more and more wide, to produce constitutional symptoms more and more grave, against which the powers of life continually struggled in an unequal contest, too often followed by a lingering convalescence and a disastrous loss of substance even when the sufferer escaped with his life. A clear apprehension of this physical condition, a condition, be it observed, purely dynamic as viewed by theorist, yet most practical now, brought with it an almost instaneous solution of the problem. What could be needed in such a case more urgently than the relief of the engorgement? What would contribute to this so promptly as the escape of the serum? What would accomplish this so speedily as a blister? Pathology and therapeutics joined hands, hypothesis, escaped far beyond the nimbus of speculation, needed only a subject to demonstate the value of a conception thoroughly original, highly philosophical, and vigorously logical in its sequences. One and many cases occurred in his practice to justify his most sanguine hopes, and to verify his confident predictions. On a far larger scale and in a far more critical case than falls to the lot of the average practitioner, it afterwards become my province to employ this special method in this particular disease. I remember well hearing the late eminent Professor of Surgery in the University of Maryland say, that he had been compelled for weeks together to desist from all operations, even the most trifling, in the Baltimore Infirmary, because of the certainty of their being followed by erysipelas and of its dangerous and unmanageable tendency. In an hospital of 750 beds, where for two years the exclusive care of this disease fell to my charge, no operations were postponed or suspended, nor was the bill of mortality materially increased on this account. I say materially, for in several instances patients were admitted moribund, and may be considered to have had no treatment at all. In one case of persistent and almost malignant obstinacy, in which the central portion of the tibia had been removed to the extent of four or five inches, the disease exhibited itself nine distinct times with extraordinary virulence. The disturbing cause here seemed to be a ragged half of a bullet that had escaped most careful examination, but which was finally discovered and removed, after which there was no similar disturbance. When a student of medicine, I saw vast abscesses opened in thigh or leg, and masses of necrosed cellular tissue looking like bunches of wet tow, raised from their depths by dressing-forceps. In no case have I seen phlegmonous erysipelas ensue after the application of the blister, and in a single instance only a few drops of laudible pus make themselves visible in a minute cavity just beneath the tunic and skin. A lady 75 years old was attacked with erysipelas of the face and head on a Sunday. The following Friday evening her physician, a gentleman of culture and large experience, was kind enough to ask me to see her with him.

*Read before the Clinical of Maryland, February 19th, 1886.

He said he had used the usual remedies, but the case had baffled his efforts, was continually growing worse and his impression was that she would certainly die. As she was the wife of a prominent citizen, a member of our profession, his interest was naturally quickened. I found the lady with a face and head very much swollen, though not to the extent I had observed them to be in other cases. The aural meati were closed so completely that no sound seemed to invoke a response, the eyes were deeply buried behind their tumid lids, consciousness seemed to have fled, a deep coma had settled like a cloud upon her faculties, her breathing was noisy with stertor. Certainly there was not much here to hang a hope upon. Pieces of adhesive plaster were speedily spread with cantharides cerate, and made to adapt themselves to such surfaces of the face and scalp as were accessible, and instructions given to let them stay until they drew thoroughly. The vesicles were then to be punctured and their surfaces covered with a stimulating cataplasm of bran and yeast, or more properly, suitable dabs of this combination were to be applied warm, and all covered with oiled silk. Internal medication was limited to a grain of quinine every two or three hours. The blisters drew finely with corresponding relief to the constitutional and local symptoms. Sunday evening, exactly forty-eight hours after they were first applied, the swollen features had nearly resumed their normal size, intelligent communication was reëstablished, food and such remedies as were indicated, were readily swallowed, and breathing, even during sleep had ceased to be noisy and stertorous. The following day vision was restored through the absorption of the effused fluids, and objects were once more naturally appreciated through exercise of this sense. In logic the *major* is said to comprehend the *minor*. This case is presented as a crucial one. Her age, the length of time that had elapsed since the attack began, the continual aggravation, the coma and other signs of meningeal or cerebral involvent, seemed to unite in a protest against undertaking further measures for her relief. Yet no success could well be more signal and gratifying than that which these measures achieved. In the instance of an army officer who had been struck with a fragment that had descended vertically from a shell exploding about his head and split open his nose, lip and chin,and in that of the wife of a surgeon, the swelling of the face and head was prodigious. All semblance of human features was lost. The lady, especially was a monster in her deformity—a veritable Medusa—a "Gorgon and Chimara dire" —her features were large, even when in health. For twelve hours erysipelas had wantoned over this fruitful field, and puffed it into huge distortions. The attack was in winter and came on after exposure to a severe north-west wind. Her husband had telegraphed for his brother, a distingushed physician in a neighboring city, but desired me to proceed at once to treat the case. This was done upon the plan already described. The blisters were applied about 10 o'clock in the morning. At my evening visit her husband told me his brother had come on, seen the case, prescribed tinct. of the chlod. of iron, which had not been given, and had returned home. By this time the blister had drawn well, giving great relief to the burning and sense of distension of the tissues. The next morning the swelling had subsided greatly, and on the morning of the third day scarcely anything abnormal was to be noted, save the slight disfigurement left by the blister. I recall four deaths that have fallen under my observation resulting from this disease, or associated with it. The first was that of a man who had been attacked with it above the elbow. When I first saw him nearly the entire limb from the shoulder to the elbow was a bag of pus. He was greatly exhausted, might indeed be considered moribund. The treatment consisted of tonics, stimulants, nutritive agents and the tincture of iron. He did not cease to fail, however, and soon sank. The second case was that of a patient suffering with this disease in the head and face. He was profoundly comatose when first seen and died in

some twelve or twenty-four hours thereafter. The third case was that of an officer whose left ilium had been smashed, probably by a fragment of shell. He told me thirteen medical men had had him successively in charge before me, and that some of them had examined his wound. Be that as it may, I took out a child's handful of fragments of bone and overcoat. The fragments of bone had become throughly detached and came away easily, without resistance. One day the nurse called attention to some inflamed patches on the corresponding thigh. They were examined and found to be angry and erysipelatous in character, without, however, much elevation above the surrounding surface. They were somewhat oval or eliptical in shape, three or four inches long by two in width. Blisters were ordered for a couple of them only, under the presumption that the inflammation would yield in all when arrested in one or more, which often happens in attacks of this nature. To my disappointment this did not occur. On the contrary, the blistered surface speedily assumed an unhealthy appearance, began to look sloughy, sank below the surface and in a day or two became quite black. At the same time the nurse told me the patient could not be got to take any food, nor even to swallow wine. The inside of the mouth presented apthous patches, and it is highly probable that a similar condition existed along the mucous track of the œsophagus and trachea. He persisted in absolute abstainance from food and drink for eighty hours, and perished. At no time, however, did the gangrenous trouble deepen or extend, and a separation around the edges of the wound indicated an effort of nature to throw off the slough, which she doubtless would have done but for life's failing powers.

The fourth and last case was the patient of a friend. He had been already under treatment for two weeks or more when my friend asked me to see him. The subject was a free liver, a faded sport and sportsman, who had given himself to duck-shooting, card-playing, fox-hunting and such like, with bibulous accompaniments. He had reached and turned his climacteric and was now going down grade. His left leg from the ankle to the knee was aflame with erysipelas, and a slight blush extended over the instep and the dorsum of the foot. Just here likewise, were two vesicles filled with reddish serum. The limb was greatly swelled, nearly twice as large as its fellow. The case looked unpromising, but I did not hesitate to recommend the use of the blister, to be extended over the entire inflamed surface. This was done and followed at proper time by the brand yeast, applied hot and enveloped in oiled silk. The results were as satisfactory as could be wished. The inflammation was arrested, the swelling was reduced, and in forty-eight hours the two limbs were of equal size. But just here an embarrassment arose similar to that in the last case. The patient obstinately refused food in any form, would not take wine or alcoholic stimulants, scouted drugs of all sorts, and with an earnestness almost suicidal in its intensity, resolutely set himself to die—which he did. Nothing discouraging occurred upon the blistered surface, but a short time before his death the bases of the two vesicles mentioned, underwent a gangrenous change. Discarding two of these cases in which no opportunity for treatment was given I cannot be far from wrong in reckoning the death at not more than ½ of 1 per cent. Yet, as I shall presently mention, all these hundreds of cases were not managed in the same way. A curious and very instructive instance of the value of vessication in this disease came under my observation a few days ago, by accident, in several senses. A young gentleman slipped on the icy pavement and in his effort to save himself, received the force of the fall on the palm of his right hand, wrenching his wrist severely. That night the pain was so distressing that he applied to an apothecary for a lotion, who with customary and assiduous alacrity gave him tinct. of iodine. This was applied, and in a short time vessicated the entire surface of the wrist and much of the back of the hand. The next morning he came to see me, com-

plaining bitterly of his suffering, and said he had not slept for two nights. The next day, Wednesday, I saw him at home. The surface touched by the iodine was peppered with vesicles, now much increased in size, the hand, wrist and half of the fore-arm inflamed, swollen and burning. In short, he was suffering from erysipelas. The arm was kept wet with infusion of lard and opium, as little of the infusion as possible being permitted to come in contact with the vessicated surface. During Wednesday night many of these vessicles ruptured, and on the following morning I punctured with a lancet many more that seemed full of fluid. The drain from this source for twenty-four hours was surprising, and as the flow of serum went on, an abatement of the swelling and vascular injection went on, *pari passu*, with it. Years ago I noticed that an inflammatory action, sometimes no more severe than a mild erythema, and again of a more angry type, would diffuse itself over the integuments of a stump speedily after amputation, which was not readily subdued by formentations either warm or cold, but which yielded promptly to the infusion of lead and opium. Having used this preparation often with success, I soon began to employ it for erysipelatous inflammations whether of idiopathic or traumatic origin. In a hospital of 1500 beds, where, at times, as many as 300 patients came daily under the observation of one surgeon, ample opportunities were offered to test its value. This was so satisfactorily proved that for years it has been my chief reliance in the milder forms of erysipelas. It is only where the peril is extreme either from the violence or locality of the disease, that I now resort to the blister. At Boradino the cannon of the French thundered in vain against the Russian center, and one change after another of their infantry was repulsed with ruinous slaughter. It was not until the "Old Guard" was hurled against their defences that their stubborn resistance yielded and the victory won. I look upon the blister as the "Old Guard." The action of the opium infusion when combined with lead, is often very prompt. A young man called to see me some weeks ago complaining of an attack of rheumatism in his ankle joints. Examination revealed the fact that he was suffering an attack of erysipelas of both ankles. After using the opium infusion for forty-eight hours no trace of the inflammation remained in either of them. But the success attending its use is not limited to congestions purely superficial. In those involving deeper seated structures its value is no less marked. I have had no case of mammary abscess to deplore since I began to rely upon it to prevent this disaster. A friend spoke to me of a case of this nature which had defied treatment, and which he then considered hopeless. At my suggestion he employed this means with complete success, and afterwards told me its action appeared to him almost supernatural, so much had it surpassed his experience with other agents in that class of cases. A lady whom I attended in her first confinement had the misfortune to have the nipples so much retracted that their extremities were much below the level of the breasts. These organs were greatly distended, nursing was out of the question, abscess with all its attendant horrors was inevitable unless the congestion could be controlled. The opium infusion did this effectually. She has since borne eight children, has always used the infusion, and has always escaped a gathered breast. In peritonitis, whether puerperal or not, in metritis, in ovaritis, in the milder forms of dysentery, in that curious form of phlebitis known as *phlegmasia dolens*, with many other painful affections we may regard this as a sheet anchor for local treatment.

I return for a few moments to the blister. There is a great reluctance among medical men to employ this agent *early* for the treatment of pneumonia. I cannot help but think that this is mistake. It is quite true that we do not now meet with many cases of an active type in which the prompt use of the blister is indicated, and in which it seems to exert its peculiar powers to best advantage. Certainly I have seen an atack of pneumonia in a young and

vigorous person cut short by a blister used in the early period of the congestion, with far greater promptitude than by the use of the lancet. In acute laryngitis it has yielded the most prompt and gratifying results. A young married lady called upon me some evenings ago, on her way home from a visit to a friend. She was quite hoarse, indeed could not speak above a whisper, and said that even to do that caused her severe pain in the region of the larynx. The attempt to swallow distressed her so much that she had desisted from it altogether for some hours. The attack had come on since early morning, she said, and had rapidly grown worse during the afternoon, although she did not seem to be aware that it portended anything serious. I prepared a small circular blister about 1½ inches in diameter, and applied it carefully just at the top of the sternum. The next day at my morning call I found all the urgent symptoms had been relieved, neither talking nor deglutition was longer painful, she had eaten and enjoyed a hearty breakfast, a dangerous malady had been aborted, and she was equal to the resumption of her daily duties. One lady I have relieved on nine different occasions by this method. To be successful one must be expeditious. The enemy is at the gates, and the gates of life! If there is any other remedy that will meet the indication with such unfailing certainty, I do not know it. Those who have seen much of continued fever cannot fail to remember instances where the patients did not seem for weeks to be in any urgent peril. They took their nourishment, stimulus, medicine in a mechanical sort of way, but with a clear understanding of what they were about, gave intelligent answers to questions, slept well, were easily aroused, and gave satisfactory promise of getting promptly up and around within a reasonable time after the fever had run its course. They have seen cases a little milder than these, and they have seen others several shades more severe. They have seen these patients in the fourth or fifth week, sometimes later, rarely earlier, pass rapidly into a coma more or less profound, from which, if they are not speedily aroused, it will soon prove to be the sleep of death. Now, just at this critical moment the blister applied to the nucha will often produce wonders. During the early stages of the disease, when there is a state of congestion apparently active, certainly extreme, its use is apt to result in disappointment. But at the later date it rarely fails to do good. A young gentleman of some 30 years of age had been lying sick of a fever for nearly or quite six weeks. He, his physician and their families were personal friends of mine, and just at this time, at the consent of the doctor, I paid him a visit of courtesy. He was cheerful, intelligent, glad to see me, thanked me for the attention. There was not a bad symptom present. Everything betokened an approaching speedy convalescence. A few days later, on meeting with his physician, a highly accomplished man, he told me our friend was very ill, and, in his judgment, hopelessly so. He requested me in a kind and earnest manner to go to see him, and to offer any suggestion to the family that might occur to me. He said further, that he had just been called urgently into the country and could not then accompany me. The fact of the young man being my friend's nephew relieved the situation of some of its embarrassing circumstances. I found the patient greatly changed from the condition he presented a few days before. His tongue was brown and cracked, his mouth was partly open, his breathing was heavy and stertorous, the coma was so profound that it was with great difficulty that he could be for a moment aroused. These and other symptoms at so late a period of the attack, left but little ground for hope or encouragement. As a last resource, a blister was ordered to the back of the neck, to extend some inches down the spine. Happily he had had the best attention, good nursing, been well sustained—the blister drew well, and in twenty-four hours he was out of danger.

What has been said hitherto has had reference exclusively to adults. I have not met with a practitioner who uses quinine endermically with children. And yet this use of that remedy is re

plete with benefits and advantages not easily appreciated except after trial. The distaste children have for the drug in any form by the mouth, often presents an insuperable difficulty to its employment in that way. Besides, when swallowed, the lingering bitterness of its taste will often cause its rejection, and that, too, when it is important that it, or one of its congeners, shall be given. To dissolve it in whisky, not Duffy's Malt, but good Bourbon, and have it rubbed into and through the child's skin, does away the above-named objection, and substitutes a method exhilarating and fairly intoxicating in its effects. Young infants soon learn to look for the rubbing with some of the eagerness that an older voluptuary welcomes the sensuous enjoyment of a Turkish bath. These poor little wan shadows of their former selves, shrivelled and shrunken by heat and cholera until their vital forces almost refuse to perform their various functions, will often start into new life under its favoring action. I order about a scruple to be mixed with an ounce of whisky, and of this from half a drachm to a drachm to be rubbed in along the spine, night and morning. Too much force must not be used, else the back will become sore. In intermitting fever, no surer way than this can be employed to stop the chill, and put the little patient on the high road to recovery. Indeed, with adults I have used this method with equal success. In the case of a gentleman passed 75 years, the third chill was stopped, and he never had another. He had a fancy that quinine disagreed with his stomach, and preferred the above way of using it, and it proved completely successful. A young lady, much given to drawing had several nervous attacks, far from being distinctly hysterical, which proved troublesome, and threatened to be serious. During a visit to Alantic City some fever came on every day, and she hurried home to escape a spell of sickness. Treatment did not afford the relief one had a right to expect from it. Languor, loss of appetite, nausea and broken sleep refused to yield to usual remedies. Assuming that there was some spinal irritation at the bottom of the trouble, I directed her spine to be rubbed twice daily with quinine and whisky, with possibly a little strychnia. The result, was prompt and surprising. Her appetite returned, she was soon able to exercise without fatigue; her sensations and tastes became natural and in two weeks she was restored to more than her average health. The addition of strychnia and arsenic to this formula, *pro re nata*, will often be found highly serviceable. In the case of our little patients, feebly and languidly convalescing from any form of disease, and of those who may be regarded as the victims of our crowded cities and our artificial life—the Tiny Tims and Paul Dombeys of current civilization—great results may often be secured from this push from behind. In those without constitutional taint, where mere feebleness and arrest of metamorphosis exists, often consequent, it may be, upon a lowering of nervous force we may expect with confidence rapid impairment and speedy restoration to vigorous health. And even in those where the lurking worm in the bud precludes the prospect of perfect recovery, much *malaise*, *ennui*, and actual suffering may be relieved or prevented.

Horace tells us it is difficult to discuss common things properly. In these remarks I have striven to avoid trenching upon the province of specialists. Indeed, the general practitioner must be like Pope's squinting poetess.

"To no one muse does she her glance confine,
But has an eye at once to all the nine."

It has been my object to do what Bacon advises, to present the subject and thus seem to lead the dance. Its possibilities are not limited to the agents nor the derangements noted in this paper. To use Newton's fine figure, we are all like children gathering a few pebbles from the shores of the ocean of knowledge. The King of Brobdingway told Gulliver he valued the man who had caused two blades of grass or two ears of corn to grow where only one had grown before, more highly than the whole race of politicians. To relieve pain, to

shorten sickness, to prolong life, to introduce improved methods into the science of therapeutics, may not satisfy entirely the demands of an honorable ambition, but may justify us in feeling that we deserve at least the encomium of this wise and illustrious monarch.

EPITHELIOMA OF THE CERVIX UTERI.*

BY R. M. HALL, M.D., OF BALTIMORE.

My object in bringing this subject before the Society this evening is twofold—first, to show how it is possible for a practitioner to err in his diagnosis; and, secondly, to show what has been denied by many practitioners in certain parts of this country. I remember seeing it distinctly stated a year or so ago, in a New England Medical Journal, that cancer of the uterus has not been known to occur in the negro race. In the Southern part of this country, according to statistics of nearly 2500 deaths among whites, one in every 121 was from cancer, while among colored people only one in about every 251. Many physicians, no doubt, in this section of the country may not even have seen a case of cancer of the uterus among colored people. I have had three cases that have come under my personal observation. One in a bright mulatto woman, age 65, who died from cancer of the cervix. During her illness I called in consultation the late Dr. McKew, who concurred in the diagnosis; another a woman aged about 60 years, who died from what I diagnosed as cancer of the cervix, taking all the symptoms into consideration; and the third case I have the pleasure of presenting the specimen from to the Society this evening.

But to return to my first proposition, I confess that in the light of subsequent events I erred in my diagnosis of the case. Knowing the rarity of cancer of the uterus among colored people, and taking into consideration the age of the patient, together with all the various symptoms connected with the case, I concluded I had a case of syphilitic ulceration of the cervix and vagina.

The literature of syphilitic affections of the uterus and appendages is very meagre so far as I have been able to learn. Bumstead and Taylor, in their late work, say syphilitic affections of the ovaries are rarely met with. According to Lanceraux they present a close analogy to syphilitic affections of the testicle. This author has only met with the diffuse form after it has arrived at the stage of atrophy; the ovaries were of the usual size or smaller than natural, fibrous in their structure, with scattered cicatrices and destitute of Graafian vesicles, although the patients had not arrived at the usual age for the cessation of the menses. Lanceraux gives a representation of a case furnished by Richet in which there was circumscribed deposit of gummy material similar to that found in syphilitic orchitis. The symptoms of these affections are said to be a slight dull pain in the region of the ovaries, possibly at the outset some increase in the size of these organs, perceptible on abdominal and vaginal palpitation, a loss of sexual passion and sterility. It is evident that these signs taken in connection with the history of the case can only furnish a probability of the nature of the disease which may be further increased by the success of anti-syphilitic treatment. No instance is known in which the Fallopian tubes have been affected with syphilis. Certain cases in which uterine tumors in syphilitic subjects have yielded to the internal administration of iodide of potash and mercury render it probable that this organ is not exempt from the late manifestation of syphilis, but nothing definite is known upon the subject sice post-mortem investigation has been wanting.

Thomas says that upon theoretical grounds it might be supposed that the diagnosis of ulcerated cancer would be so simple that few errors would occur in reference to it. This is far from the truth. A skillful diagnostician would indeed generally arrive at a correct conclusion, but I know of no disease of the genital organs of the female, unless it be pelvic peritonitis, which so frequently

*A paper read before the Clinical Society of Maryland, Feb. 19th, 1886.

gives rise to errors of diagnosis with the inexperienced.

Among other diseases he says it may be confounded with syphilitic ulcer, sarcoma and so on. From these a differentation should be arrived at by careful study of the progress of the case, by the degree of constitutional implication, and by the results of microscopic examination. A positive conclusion is not always easy. He says, let it be borne in mind too that syphilitic ulcers have been known to eat into the bladder and rectum and create very much such a state of things in the vagina as carcinoma develops.

On Friday, Nov. 20th, 1885, I was called to see Rachel C., colored, age 32. She was the mother of five children, the last one born in July, 1885. Four of the children are still living, and the last was still born. She stated that in the birth of the last child the head was delivered naturally, but owing to inertia of the uterus, the child was finally delivered by a physician. So far as I could obtain the history of the case it seems as though her health began to fail her from that confinement, although she was able to be up and about for some time afterwards. After the birth of the child she complained of pain more or less in the lower part of her abdomen and back, with metrorrhagia. On making inquiry of the family I learned that her husband was and had been suffering from some sort of disease which was offensive, and made him somewhat lame. The patient when I was called was pale and very much emaciated—the pulse was weak and about 100—the temperature was normal. She also complained of sore throat, but on examining the throat the pharynx and tonsils were free of ulcerations, neither were they congested. The tongue was sore, red, glazed, and dry. There was no eruption upon any part of the body, and the hair of her head did not fall off. On the right side above Poupart's ligament there was a glandular enlargement which was soft and fluctuating. The patient stated that the swelling gave her great pain, and I, concluding it was an abscess, plunged my lancet in it, and there exuded only bloody serum. The mons veneris was partially destitute of hair, and at the superior part of the nymphæ there was a small ulcerated surface, larger antero-posteriorly than from side to side. It was not excavated, but even with the surface. On examining her per-vaginam I found the vagina nearly filled with a number of granulations springing from its posterior wall; these were soft to the touch, but did not bleed on manipulation. The cervix had sloughed away so far that I was unable to discover the os. She suffered from incontinence of urine, necessitating the daily use of catheter. The vulva was swollen, and a portion of the thighs was excoriated. The discharge from the vagina was not profuse, neither was the smell offensive. As I stated above, believing that I had a case of syphilitic ulceration I placed her on anti-syphilitic treatment, consisting of the bi-chloride of mercury and iodide of potash. On Saturday, the 21st, when I saw her again, the tumor I lanced was as large as before, and she said it still gave her pain. I continued the treatment, and painted the tumor with iodoform in a solution of collodion.

On Tuesday, Nov. 24th, I called in consultation Dr. B. B. Browne who examined her and coincided with me in the diagnosis. The tumor on the right side being quite soft and fluctuating the doctor lanced it quite freely, and there gushed from it nothing but bloody serum. He advised the continuance of the above named treatment, also the washing out of vagina with a 1 to 1,000 solution of bichloride of mercury. On the next day, the 25th, the tumor had regained its original size, and the cut surface had healed. Notwithstanding the treatment the patient went from bad to worse, and and the fæces were passed in bed, unless controlled by the use of opium.

On examining her per-vaginam, on the 1st of December, I noticed that there was exuding from the vagina fæces, and on passing my finger up the rectum about one inch it passed directly into the vagina, the ulceration having completely destroyed the recto-vaginal septum.

I concluded there was no further use

in trying the remedies I was giving, and hence discontinued them and gave her only tonics.

She, however, continued to decline, and on Saturday, December 12, she died. About 10 A. M. I made a post-mortem, taking out only the uterus, which was so firmly adherent to the left side that I had to cut it off. Dr. Keirle was kind enough to examine the specimen for me, and reports as follows:

"The cells of the villi (uterine neck) are hyperplastic and heteromorphous; over production of large round and oval cells causes enlargement and distortion of the villi, in which there are sparse and not very characteristic pearly globes: clumps of cells have invaded the musculature, which is not arranged as a stroma but displaced and destroyed, thus indicating malignancy.

The growth is a carcinoma of surface epithelium (surface-epithelioma) having its homologue in epiblastic epithelioma (cuticular epithelioma), which conflicts with the mesoblastic origin of the uterus, and is at variance with the opinions of Virchow, whose views, however, are in accord with such origination, he admitting a mesoblast carcinoma, and holding the connective tissue corpuscle to be omnigenerative, denies that the muscular tissue has been *invaded*, and asserts that the carcinoma cells therein are antochthonous, and that the villous overgrowth is an innocent result of common irritation.—Vid. 'Cellular Pathology.' Art. Cauliflower Tumors."

N. G. Keirle, M.D.

Subcutaneous Injection of Oxides of Mercury.—Subcutaneous injections of the black and red oxides of mercury have been recently tried as an antisyphilitic treatment in the Lazarus Hospital, at Warsaw, by Dr. von Watraszewski, who has charge of the syphilitic wards. He finds that no inflammation and scarcely any pain is produced, no abscess having occurred after any of the 200 injections he has performed. The therapeutic results were most satisfactory both in recent cases and in those where the disease was of old standing.—*Lond. Lancet.*

SENNA.*

BY WM. N. HILL, M.D., OF BALTIMORE.

Cathartics, as a class of remedies, yield in importance to none and without which the practice of medicine would be reduced almost to a nullity. Hardly a disease organic or functional, can be mentioned, where there use is contra-indicated, and where benefit has not been derived from their skillful application. Their utility is not a matter of faith, the results speaking for themselves. To the most confirmed medical iconoclast they present evidence of their efficacy to the sight, hearing, smell, touch, and if necessary to the taste that compels belief, yet as a matter for discussion in a Medical Society an incurable tumor of the brain, or an extra-uterine pregnancy presents a topic for consideration of supposed superior interest. Granting that the members of this Society know all about cathartics (a position I doubt if either Trouseau, Wood or Bartholow has taken upon himself to assume) may it not be well for us occasionally to burnish up our knowledge of these important remedies. Do they not stand us in good stead in many difficult cases, and are we not to respect the bridge that has carried us safely over a deep and dangerous gulf of disease? It is not, however, to indulge in a laudation of this great boon to humanity that is the purpose of the present paper, but to detail the facts concerning the therapeutic history of an humble but respected member of the cathartic class.

A detailed botanical history of the senna plant would have no interest for us as physicians, and we pass the subject with the statement that our drug is obtained from two species of cassia, the c. acutifolia and the c. angustifolia, the first being a native of Nubia, Kordofan and Timbuctoo, and the second found in Southern Arabia, the Somali Coast and India. It is extensively cultivated in Arabia, the cultivated and uncultivated plants being articles of commercial importance in that country.

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*Read before the Medical and Surgical Society of Baltimore, Feb. 25th, 1886.

According to the researches of the best authorities a knowledge of senna cannot be traced back earlier than the ninth or tenth centuries; and it is in fact to the Arabian physicians that the introduction of the drug to Western Europe is due. Isaac Indacus who wrote probably about A.D. 850—900, and who was a native of Egypt, mentions senna, the best kind of which, he says, is that brought from Mecca. It is enumerated among the commodities liable to duty at Acre, in Palestine, in the 12th century. In France in 1542 a pound of senna was valued, in an official tariff, at the same price as a pound of pepper or ginger. A species was cultivated in Italy for medicinal use during the first half of the sixteenth century. It is now produced in Nubia by the peasants who make two senna harvests annually, gathering the shrubs and exposing them to the burning sun till dry. It is sent to market via Massowah, Suakim, Cairo, and Alexandria. The difference in grade is more a matter of interest to the druggist than to physicians. A chemical analysis of senna shows its active principle to be a colloid body easily soluble in water, but not in strong alcohol, the activity of which is again shown to be due to the presence of a peculiar acid called cathartic acid. The alkaline salts such as are formed by the combination with ammonia or magnesia, in the old black draught, have been shown to possess the purgative properties of the drug in a concentrated form.

Senna is adulterated to some extent by the leaves of the argel plant, whether with intent of improving the drug or due to custom or prejudice is not certain, but it has been proved that this adulteration adds to its griping properties, and is therefore to be deprecated. Referring you to the "Pharmacopœia of Flühiger and Hanbury," to which I am indebted for most of the foregoing facts, for a more extended discussion of the history of the drug, we pass to a consideration of its therapeutic properties.

Authorities, in common with our every-day experience, agree in ascribing to senna efficient properties as a cathartic. Trouseau however, disagrees with the statements of Bartholow and Wood that senna produces very watery stools. In fact Trouseau states the discharges are more feculent, and ascribes its effect to the increased peristaltic action by which "the contents of the small intestine descend rapidly without any increased discharge of the biliary, pancreatic and mucous fluids," and explains the frequent colics arising from its use on theory that the pain is produced by the contraction of the muscular fibres of the colon filled with hardened fæces. According to the same authority the power of senna extends to the muscular fibres of the uterus and to the bladder. Senna is to be preferred as a cathartic by reason of the fact, now generally admitted, that "its purgative action is not followed by intestinal torpor or constipation." The objections to its use lie in its griping properties and its disagreeable taste both of which can be mitigated by aromatics.

A multitude of preparations of which senna forms the active part have been made, varying in character from that horror of our ancestors, the black draught of senna and salts, to the modern confection; but among them all, we think, no superior to the article now presented can be found.

Its mode of preparation, in no sense a secret one and which is appended, has been the subject of much thought and care to the well known pharmacist, of our city, Mr. J. F. Hancock, and he has succeeded in giving us a cathartic (Liquid in form—no small desideratum when we consider how frequently we require their use in that form) at once agreeable and efficacious, not causing griping of any consequence in cases where I have used it, and producing nearly natural stool. The name liq. senna dulc. has been given to it.

Mr. Hancock states the manner of making this preparation to be as follows: A sufficient quantity of senna is treated with strong alcohol until the disagreeable taste of senna is removed; the senna is then dried, the alcohol recovered by distilation; the deresinized senna is then percolated with cold water to exhaustion; the resultant percolate is slow-

ly evaporated over a water-bath heat; flake manna is added in proportion of one fourth the amount of senna employed; when reduced to a proper consistence, it is filtered and the flavors of coriander and cinnamon added in conjunction with deodorized alcohol ℥i. to one pint each pint of the finished product represents ℥viii senna and ℥ii of manna. The maximum adult dose is fl. ℥ii.

Mr. Hancock also manufactures a cathartic lozenge, containing in each 8 grs. of senna having all the qualities of the drug without its griping effects and disagreeable taste. He presents the members with a specimen which he hopes they will use and be kind enough to enform him as to its efficacy and the dose experience may dictate.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD FEB. 19, 1886.

Dr. R. M. Hall read a paper on

A CASE OF EPITHELIOMA OF THE CERVIX UTERI.*

DISCUSSION.

Dr. B. B. Browne was much interested by Dr. Hall's paper. From the history of the case he had taken it to be of syphilitic origin. He has seen two other cases occurring in negro women, who had syphilitic histories—their husbands also had syphilis. These women had ulcerative processes going on in the cervix uteri, which were to all appearances the same as that seen in Dr. Hall's case. The ulceration was pronounced and in one case perforated the recto-vaginal septum. The cicatricial bands were broad and firm. He would like to know if a cancer could form upon a syphilitic ulceration and if then they could be histologically differentiated.

Dr. N. G. Keirle thought one could differentiate these two conditions better by their macroscopic than by their microscopic characteristics. For the two forms of cell infiltration occurring in these processes are sometimes very similar.

Dr. John Lynch has seen three cases of cancer of the cervix, occurring in colored women. He thought that two of these cases admitted of some doubt, but that the third was absolutely typical. He thought one hardly justified in saying that "cancer of the cervix did not occur in colored women."

Dr. W. P. Chunn thought that in the last five years he had seen, at least, a dozen undoubted cases of cancer of the cervix in colored women. At this time he had three under his care. He don't understand why they should be exempt, as they are subjected to the same accidents as are said to give rise to it in white women. They certainly have laceration of the cervix quite as frequently as white women, and this is said to be one of the most frequent causes of the process. He has never seen a chancre either on the cervix or in the vagina. He has seen a cancer develope over a syphilitic erosion.

Dr. B. B. Browne did not wish to leave the impression that the cases referred to by him were primary syphilitic lesions, but that he took them to be local expressions of a constitutional trouble.

Dr. N. G. Keirle has heard reports of cancer arising from gonorrhœa and syphilis, but thinks they only occur under these circumstances in persons predisposed to the cancerous process. He had treated a man for syphilis and later his wife for the same trouble. She referred her symptoms to the uterus supposing that she was suffering from hemorrhage from that organ—he deferred making an examination for some time, but finally was compelled to do so as the woman's condition was becoming alarming. Vaginal examination revealed to him a squarely cut stump from which the cervix had been spontaneously amputated. There was no odor, but the process was undoubtedly that of true cancer. He thinks the ordinary cancer in which all symptoms are present, is a true *adenoma*

*See page 403.

beginning in the mucous crypts of the cervix. These cases usually are accompanied by much sloughing, due to interference with the nutrition of the part from obstruction to the flow of blood by the great cell infiltration. On the other hand the *epithelioma* as occurring in this region, begins in the villi of the mucous membrane and presents a condition the reverse of that found in the adenoma, that is, the villi grow *out upon* the surface instead of growing *into* the substance of the organ as does the adenoma. He thinks Dr. Hall's case an epithelioma and not an adenoma.

Dr. R. M. Hall. Did Dr. Chunn's cases present all the symptoms of epithelioma—as bad odor, lymphatic involvement, etc.?

Dr. W. P. Chunn said he did not examine the glands, there was bad odor, but not especially so. He was sure they were cancers.

Dr. E. G. Waters read a paper on

ENDERMIC MEDICATION.*

DISCUSSION.

Dr. John Lynch corroborates Dr. Waters' statement respecting the success of blisters in idiopathic erysipelas. The blister should be of sufficient size to cover entirely the inflamed area.

Dr. H. Clinton McSherry has had most happy results from the application of blisters over the thorax in early stages of pleurisy and pneumonia. In acute laryngitis without œdema blisters give great relief and may in some cases abort an attack.

Dr. Randolph Winslow asked Dr. Waters whether he had used blisters in the deeper forms of erysipelas or only in the cutaneous variety.

Dr. Waters replied, he had employed visication only in the simple cutaneous erysipelas.

Dr. Winslow said he thought this a very important point: Erysipelas is usually classified as cutaneous, phlegmonous and cellular, but there is probably a difference in the pathology of the superficial and deep forms, and whilst vesication might be of advantage in the superficial varieties, other methods of treatment would almost certainly yield better results in the deeper. He also called attention to the fact that the superficial variety rarely terminated fatally, but after a certain length of time begins to subside, and in 24 or 48 hours marked improvement might be noticed, so he did not know how much to attribute to the remedy in these cases. Many cases of erysipelas are accompanied with vesication, as in a case recently under Dr. Winslow's treatment, where the hand and arm were as freely blistered as if cantharides had been applied to the surface, with free secretion of serum, and he had not found that such did better than those in which it did not occur.

Dr. Lynch stated that a blister placed upon the sound skin will prevent the advance of erysipelas beyond that point, but it is difficult to understand the *modus operandi* in such cases, certainly it is not on account of its depleting effect upon the healthy skin. We must accept statements in regard to the treatment of cutaneous erysipelas with great caution, but if it is a fact that blistering will arrest its progress, we are to be congratulated upon having heard Dr. Water's paper.

Dr. W. H. Norris has never departed from the practice of bleeding and blistering, thinks physicians of the present day make a mistake by dispensing with these valuable agents.

Dr. E. M. Reed, thinks the general condition of patient should be considered before blistering in erysipelas.

Dr. John Lynch has tried nearly all of the treatments recommended in erysipelas and gets about the same result. Thinks the tendency in the disease is to run a regular course which is but little affected by any treatment. Thinks fatal cases are the result of hyperpyrexia.

Dr. A. C. Pole agrees with Dr. Lynch. He recently prescribed for a patient with erysipelas, and did not discover until the patient was convalescing that he had made a mistake in the dose. The result was as good as if the prescription had been as he intended it.

*See page 397.

Dr. I. E. Atkinson expressed skepticism upon the abortive treatment of erysipelas. Don't think blistering or marking by nitrate of silver has any effect at all. Don't think that fatal cases are the result of hyperpyrexia. When an erysipelas of the upper part of the body or head proves fatal he thinks it due to an extension of the process to the meninges. In his opinion the disease is hardly sufficiently dangerous, nor are the chances of doing good by blistering enough to justify us in risking the disfiguring cicatrix that may follow a blister. Cannot possibly conceive the advantage to be derived from blistering in migratory erysipelas. Many cases as Dr. Winslow has just said blister spontaneously without any apparent benefit upon the course of the disease.

Dr. W. D. Booker agrees with Dr. Atkinson as to the cause of death in these cases being often a secondary meningitis. He related a case of fatal meningitis resulting from a facial erysipelas complicating perforation of the tympanic membrane.

Dr. Wm. A. Moale made some remarks upon, and showed photographs of a case, upon which he had performed

DOUBLE SUPRA-CONDYLOID OSTEOTOMY.

He did McKewin's operation first on one leg and after an interval of about eighteen months on the other one.

The operation was a success in every respect, the patient being able to walk perfectly. He exhibited the instruments used in doing the operation. His results on several of these cases have been so uniformily favorable that he would advise the operation in all of these conditions.

In answer to Dr. Platt, as to how long after the last operation was it before the patient could walk without assistance, he said, she walked perfectly after about four months.

Dr W. B. Platt thinks Dr. Moale's results remarkable as in most of these cases the internal ligaments of the knee-joint are so relaxed that they walk with difficulty.

Dr. J. Edwin Michael thinks this the first case of double supra-condyloid osteotomy reported in this city.

He has done the operation on one leg. He adopted MacCormack's operation, and observed antiseptic precautions. So far as straightening the leg goes, the operation was a success, but can not report on the progress of the case as the patient left the hospital and did not return.

He thinks the results justify the operation.

Dr. John N. Mackenzie related a

CASE OF LYMPHOID GROWTH IN THE PYRIFORM SINUS.

The tumor arose from the anterior, right-hand side of the pyriform sinus. It grew until it almost entirely obliterated the opening to the larynx. It was movable. To remove the growth it became necessary to cause retching when it was partially extruded. It was then grasped with the forceps, which were held by an assistant, while the wire of an ecraseur was passed around its pedicle and in this way severed it from its point of attachment. Though the growth itself was very vascular, but little hemorrhage accompanied the operation.

There has been no return of the growth. Dr. Mackenzie has not been able to find any report of a growth arising from this locality.

Dr. W. T. Councilman to whom the tumor was referred for microscopic examination reported it to be a papilloma. In size, it was about that of a testicle of a man. Pharyngeal growths usually arise from posterior wall, rarely from the anterior. Cancer has been found in the pyriform sinus.

ASTLEY COOPER PRIZE—The next triennial prize of £300 will be awarded to the author of the best essay or treatise on the Origin, Anatomy, Results, and Treatment of Tubercular Diseases of Bones and Joints. Essays are to be sent to Guy's Hospital on or before January 1st, 1889, addressed to the physicians and surgeons of that institution.—*Lancet.*

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BALTIMORE, MARCH 20, 1886.

Editorial.

THE IMPORTANCE OF A CORRECT DIAGNOSIS OF SMALL-POX.—Some of our readers will recall the case of Dr. Purdy, to which reference was made in this JOURNAL (Dec. 5th, 1885) over three months ago, in connection with a suit for damages, in which he was mulcted by a jury to the extent of five hundred dollars for a supposed failure to make a correct diagnosis of a small-pox. The circumstances of this case were fully related at the time, and sympathy was expressed for Dr. Purdy in his medico-legal troubles.

The fact that the Medical Society of the County of New York was so prompt in espousing Dr. Purdy's cause was considered a striking proof of the injustice of the charge brought against him, and a justification of his action in connection with the patient who had instituted a suit for damages against him for his incorrect diagnosis. This suit has been extensively commented on by the various medical journals throughout the English speaking countries, and it has served a useful purpose in calling attention to the importance of making a correct diagnosis of small-pox. It is generally taught in medical works, devoted to a description of small-pox, that the diagnosis of this disease is attended with comparatively few difficulties. The invasion of the disease, in typical cases, is so characteristic, and its physical aspects are so well marked that errors of diagnosis should rarely occur. Whilst this is true of the disease in its ordinary manifestations the various modifications of atypical cases present many embarrassing features, and the most experienced observers have fallen into the gravest errors of diagnosis. The intense outburst of professional sympathy for Dr. Purdy was an illustration of this fact. It has been shown that during the prevalence of great epidemics the professional mind is less acute in recognizing distinctions between kindred diseases. Errors of diagnosis are of frequent occurrence, and unfortunate results seem inevitable. In the case of small-pox an error of diagnosis is a matter of the most serious concern. A disease so loathsome and so contagious as this speedily arouses great anxiety and fear. It is extremely urgent that its true character should be discovered that isolation and other means of limiting its spread may be instituted without delay. A snap diagnosis may be unwillingly extorted from the attending physician if the least intimation of his fears or suspicions are suggested; hence the embarrassing complications which surround the diagnosis of small-pox cannot be over-estimated. Whilst the interests of the public demand that the small-pox patient should be isolated, the dangers to a patient from such an isolation are of equal consideration. To cast a patient who has some other form of eruptive disease into a small-pox hospital is an error from which every honest practitioner would shrink. The records of small-pox hospitals are prolific in statistics of this nature. In a very instructive article "On the Diagnosis of Small Pox," (*Journal of Cut. and Venereal Diseases*, March, 1886,) Dr. P. A. Morrow, of New York, has collected a number of valuable statistics and facts bearing upon this subject. We present the following facts from Dr. Morrow's article. He says:

"Neumann, who had charge of the Vienna Small-pox in the epidemic of 1872-73, reports that thirty-five patients with meales, scarlatina, erythema, etc., were erroneously admitted as having small-pox.

The following statistics, taken from the records of the Small-pox Hospital of this city, from 1880-1885 inclusive, were kindly furnished me by Dr. F. W. Chapin. During this period, over 2,500 cases of small-pox were admitted into the hospital. Thirty-one cases wrongly diagnosed as small-pox are classified as follows: Typhus, 13; measles, 9; syphilis, 3; acute eczema, 1; varicella, 1; psoriasis, 1; acne, 1; purpura hemorrhagica, 1; malaria, 1;—making a total of 31 cases. On the other hand, eleven cases of small-pox wrongly diagnosed are thus classified: Typhus, 8; typhoid, 1; scarlet fever, 1; measles, 1. A total of 42 instances of mistakes as regards small-pox. In addition to these there was a much larger number of wrongly diagnosed cases which were received at the Reception Hospital in East 16th street and not transferred to the Island Hospital.

An examination of the record of the 'Reports of Contagious Diseases submitted to the Board of Health of this city for the past twelve weeks ending January 16,' discloses the fact that seventy-two cases of small-pox had come under the observation of the Health Board within this period. In addition to these cases of undoubted small-pox, thirty-eight cases were reported as such, which, upon investigation, were found not to be small-pox. An analysis of these 38 cases shows that the disease mistaken for small-pox were represented as follows: Varicella, 17; syphilis, 5; measles, 3; lichen tropicus, 1; lichen, 4; vaccinia, 1; herpes, 1; pemphigus, 1; miliary fever, 1; sudamina, 1; erythema, 1; urticaria, 1."

These facts teach a very important lesson in illustration of the difficulties which embarrass the physician in making a correct and prompt diagnosis of eruptive diseases, but they show, also, we think, a certain amount of carelessness in arriving at an opinion in regard to the nature of such conditions. Whilst it must be admitted that errors of this nature will unavoidably occur in a certain number of cases, the responsibility for such mistakes cannot be shifted in a light way from the medical attendant's shoulders. It seems to us important that more than ordinary care should be exercised in forming an opinion in regard to the nature of an eruptive disease and that equal caution should be observed in expressing the same. The various symptoms and physical aspects of the eruptive diseases show certain points of resemblance in their premonitory stages which may lead to confusion. The element of time is an important factor in solving the doubt, and this fact should be given primary consideration before arriving at an opinion in every case involving questions difficult of solution. Dr. Morrow has very carefully presented the symptoms and features observed in the eruptive diseases in the article to which we refer. We would commend this paper to the perusal of such of our readers as are dealing with the clinical features of the eruptive diseases, as one well-worthy of careful study.

The Late Prof. Austin Flint, Sr.—The sudden death of Prof. Austin Flint, Sr., will awaken a feeling of deep regret in professional circles both in this country and in Europe, where he was universally recognized as a physician of the highest social and scientific worth. Professor Flint belonged to that small coterie of distinguished medical men who have helped to make American medicine famous, and who have done so much in this century to enlarge and widen our knowledge of the medical sciences. That position which Gross occupied with respect to American surgery and Marion Sims sustained to American gynecology, Austin Flint, Sr., held in respect to clinical and practical medicine. By his writings, teaching and practice he has greatly enriched the literature and knowledge of the healing art, and has transmitted to coming generations the legacy of an earnest culture, careful observation, and systematic study of disease. But not only has Prof. Flint added to the renown of the American profession; his fame has extended into foreign countries, and his opinions and observations have become incorporated into Continental languages. In Great Britain Prof. Flint was, perhaps, the best known of American practitioners. Only quite re-

cently our able contemporary, *The Lancet*, honored him with the sobriquet of "Watson of the United States." Such in fact is the relation he sustained to the profession of this country, and from this standpoint it is pleasant to view his honored professional position, his eminent culture and attainments, his high and pure character, and his classical writings and oratory.

A life well spent in earnest labor is brought to its close whilst crowned with the highest honors within the gift of that profession he has sought to elevate and advance. Such is the honored privilege granted to but few men. It has been fittingly bestowed upon Austin Flint, Sr.

Miscellany.

A Hint on the Treatment of Ringworm.—Dr. R. W. Leftwich writes to the *Lancent*, February 6th, 1886: Last August a lady asked me to examine her nurse-maid's head. I did so, and found a well-marked patch of ringworm about an inch an a half in diameter. The mistress was naturally unwilling to expose the contagion her children, who presented no sign of the disorder, and almost equally unwilling to part with the girl for a time. After some reflection I told her I thought the difficulty might be gotten over with only very slight risk to the children, and treated the case in the following way. Having cut the hair close to the scalp, all round the patch, I first painted it with an alcoholic solution of iodide of mercury—an old-fashioned but excellent remedy, obtained by adding calomel to tincture of iodine and using the supernatant colorless fluid. As soon as the slight soreness it produced had passed off, I applied an iodine plaster, obtained from a formula in Beasley's book and attributed to Roderburg, an ounce of the plaster containing a half a drachm of solid iodine. This spread on kid, was carefully applied to the patch, which it overlapped all round. At the end of a fortnight it was removed, and the ringworm appeared practically cured. To make sure, however, it was again painted with the above-mentioned solution and a fresh plaster applied for another fortnight. Upon being taking off, the whole surface of the patch was found covered with short hairs. No other patch has made its appearance upon the head or elsewhere, and not one of the three children with whom the patient was in daily and hourly contact, took the complaint. Possibly the plaster alone would have been sufficient, but I thought it safer to use the paint in addition, and I feared that if I used a more powerful plaster the irritation might tempt the patient to remove it. I might also have used a plaster containing oleate of mercury, but doubted whether it could be made sufficiently adhesive. The advantages of this mode of treatment are obvious enough, for by its means the risk of the disease being spread by actual contact, by means of caps and by the common use of hair-brushes, is reduced to a minimum. I find no allusion to this method in the ordinary works on the subject, and therefore infer that, if new, it is not widely known.

Unconscious Impregnation.—At the recent Manchester assizes a man named Jackson, a dentist, was sued for damages for the alleged seduction and consequent pregnancy of a young woman aged twenty-five. The facts, as stated in evidence, were so remarkable that it is not surprising the jury were discharged without giving a verdict. The case is interesting from a medico-legal point of view, and shows the danger of administering anæsthetics in the absence of the third person. It appears that the woman went to Jackson for the purpose of having a tooth extracted, and whilst under the influence of gas the defendant, according to the allegation set forth in the statement of claim, ravished her. The plaintiff at the time was engaged to be married, and it does not seem that she made a complaint to her intended husband of the supposed assault—in fact, she even allowed the banns of marriage to be published, though cognisant that she was *enciente*. Two questions arise in connection with the case of the highest import. Is it possible for intercourse

with a virgin to take place during the short period of insensibility and semi-consciousness following the administration of nitrous oxide gas? We take it that, although possible, it is in the highest degree improbable. But there can be no doubt that, granted the accomplishment of the act, the answer to the query, "can unconscious impregnation happen under such conditions?" must be in the affirmative. Cases are on record in which women have conceived during sleep and the state of anæsthesia induced by gas is only another form of sleep. If we are correctly informed of the facts, we cannot understand why the plantiff proceeded against the defendant by civil process and not by criminal indictment, for if the story of the woman is true, surely the man was guilty of felony. Perhaps the fact that the plaintiff did not make immediate complaint of the alleged assault weighed heavily in the balance on the side of the accused. Such a charge as the above referred to is difficult and may be impossible to refute, and consequently it is only just that the strongest corroborative evidence should be required to justify a conviction or a verdict for damages, or, failing that, there should be a complete investigation of all the collateral circumstances as regards the conduct of both parties *re* the charge, and also a searching inquiry into their general credit. From an impartial survey of the medico-legal and moral bearings of the case as reported in the *Manchester Guardian*, we cannot help expressing the opinion that upon the evidence before them the jury could scarcely have found for the plaintiff.—*London Lancet*, February 20th, 1886.

Inhalation of Blood.—For anæmic patients in whom the preparations of iron are ill tolerated, M. Fubini avails himself, with marked benefit to the patients, of pulverisations made of a mixture composed of 80 parts of a solution of chloride of sodium (¾ per cent.), and 20 parts of defibrinated ox blood. An ordinary spray suffices for carrying out the procedure, which may be repeated without danger five or six times a day, each inhalation lasting about fifteen minutes. Each sitting ought to use up about twenty cubic centimetres of difibrinated blood. The patients experience, after having taken several deep inspirations, a slight giddiness, which disappears on assuming the horizontal position or after drinking a glass of wine. Absorption takes places rapidly from the respiratory passages. M. Fubini remarks on the perfect tolerance by patients of the inhalations, and on the certainty with which hæmoglobin is absorbed by the respiratory passages. —*Lancet*, Feb. 20th, 1886.

The Internal Administration of Antiseptics.—The administration of antiseptic drugs, either as prophylactics or as remedies, has been frequently resorted to in the treatment of infective diseases, but not hitherto with an amount of success which has encouraged the profession at large to adopt the method. Some experiments, however, which Dr. Theodore Cash is now conducting for the Local Government Board, appear to justify the hope that this line of treatment may eventually be useful. In a communication recently made to the Physiological Society, he stated that he had been led to test the influence of perchloride of mercury, because it was retained in the body for some days after its administration had ceased, and because it was still a powerful germicide even when very greatly diluted. He found, in an experiment on a rabbit, that after a quantity of perchloride of mercury, equal to about 8 milligrammes per kilogramme of body-weight, had been injected hypodermically, in divided and highly diluted doses in the course of seven days, the animal only suffered a passing disorder after inoculation with a virus of anthrax which killed another rabbit in forty-four hours. The animal, moreover, was found to be protected against further inoculations with virulent anthrax. A smaller dose (equal to about 5 milligrammes per kilogramme of body-weight) was found to delay, but not to prevent, the onset of the disease. The number of bacilli found in the blood after death in such a case was very small, but it was found that their virulence had not been diminished,

the blood of the animal producing an unmitigated and unmodified attack of anthrax in other animals.—*Br. Med. Jl.* Feb. 13th, 1886.

Remarkable Fecundity.—Dr. C. L. Fletcher, of Wing's Station, N.Y., writes to *The Medical Record* that a woman residing in that town has given birth to twenty-five children. She is hardly past the prime of life, and is now in good health, having recently recovered from an attack of scarlet fever. "When the writer was in practice in Northern Vermont he often had occasion to prescribe for the different members of a family in which the mother had given birth to twenty-five children, having three pairs of twins in the crib at one time. The same woman had two sisters who had borne respectively twenty-two and eighteen children, making a total of sixty-five from the three sisters. It is needless to say that all the families are poor in the financial sense."

A Note on Lewinin, the New Local Anæsthetic.—Dr. N. A. Randolph, of Philadelphia, says in *The Medical News*, March 15th:

"In the editorial columns of *The Medical News* of February 13, 1886, there is given a brief account of the physiological properties of a semifluid resin obtained from the root of *Piper methysticum*.

In the method employed in obtaining it (extraction by petroleum-ether) two resinous bodies are obtained, the resin of lesser density only being efficient. To this body Lewin, its discoverer, applies in his original communication the rather cumbrous title of "Alpha Kawa Resin," for which I have ventured to substitute the name lewinin, as above.

Although I have not been able to obtain, in my experiments with the extract in question, results as marked as those presented by Lewin, several points of clinical interest have arisen, which will, I think, be of interest.

When the semifluid lewinin is placed upon the tongue, there is a momentary burning sensation with increased salivary secretion, followed by a local numbness, which, while extremely superficial, is recognizable for more than an hour. Some pallor of the mucous membrane at the point of application is noticeable. I have several times swallowed about five grains of the extract thus placed upon my tongue without appreciable results other than those noted.

Lewinin is too painfully irritating to apply in practice to the human conjunctiva, but it is my belief that, by the previous application of cocaine, the lewinin in solution could be instilled into the conjunctival sac, and produce its characteristic effect of prolonged local anæsthesia before the more temporary effect of the former drug had passed off.

The extract will probably be of service in dental practice, as its application certainly mitigates the discomfort of operations on the teeth of those suffering from sensitive dentine.

The most marked practical benefit, however, to be expected from the use of the drug is in cases where only a relatively superficial anæsthesia is desirable. Thus, as would have been expected, the drug is of value in rhinological practice.

Dr. Harrison Allen, to whom I handed a fifty per cent. alcoholic solution of lewinin, kindly reports that, in practice, he has found a number of cases of nasal trouble in which the drug could not only be availably substituted for cocaine, but in which its action was more satisfactory.

The extract just discussed was prepared for me something over a month ago by Mr. Llewellyn, of this city, and was, I believe, the first specimen of the drug produced in this country."

Milk-diet in Chronic Nephritis.—In view of the fact that milk-diet had been emphatically recommended by many observers (Senator, Sparks, and Bruce, etc.), Dr. A. S. Trubatcheff, (*Vratch*, No. 46, 1885, p. 763) undertook a series of comparative observations on four patients with chronic nephritis (three with the parenchymatous, one with the interstitial form), each of whom received ordinary hospital diet during one period, and either mixed or pure milk-diet during a subsequent period of equal dura-

tion. The results were as follows:

1. An exclusive milk-diet invariably led to a marked increase of the daily and percentage amount of albumen in the urine.

2. The patient's weight fell considerably, without any marked change in his dropsical state.

3. A mixed milk-diet also led, in the majority of the cases, to an increase in the daily and percentage amount of albumen excreted.

4. Neither pure nor mixed milk-diet produced any marked increase in the amount of urine.

The author is now studying the assimilation of protein by nephritic patients receiving milk-diet, which study will enable him to settle the question of "good or harm" of the treatment.—*London Medical Record*, February 15, 1886.

Obituary.

PROFESSOR AUSTIN FLINT, Sr.

Professor Austin Flint, Sr., died suddenly at his residence in New York City on Saturday, March 13th, of cerebral apoplexy. He had spent Friday evening at Bellevue Hospital Medical College examining students who were applicants for the degree of M.D. Soon after leaving the college, and after his arrival at home, he was stricken with apoplexy and passed into coma, from which he never aroused. At the time of his death Professor Flint was 74 years of age. He was born in Petersham, Mass., on October 20th, 1812. He was descended from a family of physicians, his great-grandfather, grandfather and father having preceded him as honored practitioners of medicine. It may be said that in this way he was in a measure equipped for the great service he has rendered to the science and practice of medicine. Professor Flint pursued his collegiate studies at Amherst and Cambridge, and received his degree of M.D. from Harvard in 1833. In 1836 he established himself in practice in Buffalo, N. Y. In 1844 he was appointed to the chair of the Institutes and Practice of Medicine in the Rush Medical College, of Chicago. He was the editor of the *Buffalo Medical Journal* for ten years from 1846 to 1856. During the year 1852 he accepted the chair of the Theory and Practice of Medicine in the University of Louisville, which he retained until 1856. During several winters, he was engaged in teaching Clinical Medicine in New Orleans. In 1859 he removed to New York City and subsequently became Professor of the Principles and Practice of Medicine in Bellevue Hospital Medical College, which position he held up to the time of his death, his last work being discharged in connection with this school.

In 1872 Professor Flint was elected President of the New York Academy of Medicine, and in 1883 was elected President of the American Medical Association and presided over the meeting held in Washington in 1884. Upon the organization of the Ninth International Medical Congress, he was chosen its President. He had accepted an invitation to deliver an address before the British Medical Association in July next. It will thus be seen that Professor Flint has been greatly honored by the profession by his selection to the most important positions within its gift. These honors were as modestly and gracefully worn as they were appropriately bestowed upon one whose professional labor and zeal have greatly added to the fame and honor of American medicine. Professor Flint was equally well-known as an author, teacher and practitioner. In whatever direction his talents and energies were turned the results were eminently prolific. As an author there is, perhaps, not an American writer on the Practice of Medicine who has compassed so wide a field and whose writings have added so largely to the fame of its literature. His classical "Treatise on the Principles and Practice of Medicine" has passed through numerous editions and now stands as one of the standard text-books in the English language upon this subject. Professor Flint has likewise written a number of manuals on different subjects; whilst of the monographs, addresses and lectures which have emanated from his pen, it would take much space to enumerate.

Aside from his literary and scientific attainments Professor Flint was highly esteemed for his eminent personal qualities. In all of the relations of life he was the cultivated scholar and model gentleman. His death at this time is a great loss and his position in professional ranks is one which it will be difficult to fill.

Medical Items.

The Rush Medical College, of Chicago, has recently graduated 156 student.

The Medical Department of the University of the city of New York at its commencement, held March 6th, graduated a class of 173.

Dr. E. F. Wells, of Minster, Ohio, has been elected Professor of Materia Medica in the College of Physicians and Surgeons of Chicago.

The fifth German Congress for Internal Medicine will take place, from April 14th to 17th, at Weisbaden, under the presidency of Professor Leyden.

Dr. D. G. Brinton, the well-known editor of the *Medical and Surgical Reporter* and the author of a number of popular medical works, has recently been made laureate of the Societe Americaine de France for 1885, and has been awarded the medal of the Society for his works on the aboriginal tongues of America.

A Medical College has recently been organized in Pittsburg, Pa., under the name of Western Pennsylvania Medical College. The new college will begin lectures in October next.

The *Medical News* states that a committee has been organized to collect funds for the erection of a monument to the three distinguished French physicians, Bretonneau, Velpeu. and Trouseau.

Dr. M. Goldsmith, of Rutland, Vt., has agreed to give in trust to the New York Pathological Society, when incorporated, the sum of $2,000 and wills the sum of $3,000 more, payable at the death of his wife and of himself.

Dr. A. Y. P. Garnette, Jr., died at his home in Washington City, last week. He was a a promising young physician. His death is a severe affliction to his distinguished father and to a large circle of friends.

Governor Hill, of New York, has nominated Dr. C. D. Phelps, for Health Officer of the Port of New York, and Dr. J. Douglas, Mr. M. B. Blake, of New York City, and Mr. C. S. Higgins, of Brooklyn, as Qaurantine Commissioners.

Dr. Gasper Griswold, of New York City, Demonstrater of Anatomy at Bellevue Hospital Medical College, died suddenly on March 4th, from peritonitis. He was only 29 years of age, but had already given promise of a brilliant professional career.

The Alumni Association of the College of Physicians and Surgeons met March 12, and elected the following officers: Dr. G. H. Rohé, president; Dr. Joseph P. Conley, vice president; Dr. S. M. Free, treasurer, and Dr. Harry Friedenwald, secretary. Drs. C. F. Bevan, chairman; Spencer M. Free and F. R. Nordmann were appointed the committee, during the ensuing year, to pass on the annual prize essay of the association.

The rates given to the Delegates to the American Medical Association meeting, May 4, in St. Louis, have been fixed by the different Railroad Committees of the country, at one and one-third fares for the round trip. Delegates must pay full fare coming, and will receive on application, from the Agent at starting point, a certificate, which when signed by the Chairman of the Local Committee of Arrangements will entitle them to the reduced return rate. No reduced return ticket will be issued unless the purchaser can show a certificate issued by the Agent from whom he purchased the going ticket, and signed by the Chairman of the Committee of Arrangements.

The fourteenth annual commencement of the College of Physicians and Surgeons, took place Monday, March 15th, at the Academy of Music. Prof. Thomas Opie, dean announced the graduates, 146 in number. Professor John S. Lynch conferred the first college prize upon Harry Friedenwald, of Maryland. Prof. A. B. Arnold presented the other prizes, as follows: Brown memorial prize, Joseph C. Connelly, Pa.; Howard memorial prize, Edwin Kirkpatrick, Pa.; Bobbitt prize, N. T. Carswell, Ga., Nicholson prize, Charles W. Pritchett, Jr., Va.; Worthy of honorable mention—David Davis, N. J.; H. W. Dew, Va.; Geo. R. Miller, Conn.; J. Edmund Brown, Me.; A. S. Priddy. Rev. T. D. Anderson of this city, delivered the valedictory.

The University of Maryland, School of Medicine held its seventy-ninth annual commencement at the Academy of Music, on Wednesday, the 17th inst., and graduated seventy-eight Doctors of Medicine and twenty-seven Doctors of Dental Surgery. In the Medical Department, the gold medal, the Miltenberger prize and the Chisolm prize were all awarded to Dr. Ridley Nott, of England; the Tiffany prize to Dr. Howard R. Weber, of Maryland. In the Dental department the gold medal was awarded to Dr. W. Eppes Proctor, Jr. of Virginia. A large number of special prizes were also awarded in this department. In awarding his various prizes to Dr. Nott, the Provost S. T. Wallis, Esq., paid a graceful tribute to the talent and industry which had enabled him to overcome the many difficulties which had beset his path and to fight his way to such distinction. We understand the Faculty have also elected Dr. Nott to the position of assistant resident physician to the University Hospital. Col. Wm. Allen of the McDonough Institute delivered a thoughtfal and scholarly address to the graduating class, which was highly appreciated by all present.

The Alumni Association of the University of Maryland, School of Medicine, held its annual reunion at the Eutaw House, on March 17th, at 8 P. M. Dr. J. Carey Thomas, the president, made an appropriate address of welcome to the class of 1886. The oration was delivered by Dr. C. H. Ohr, of Cumberland, of the class of 1834. Dr. Ohr's remarks were highly interesting and appropriate to the occasion. The following officers were elected for the ensuing year: President, Dr. H. M. Wilson; vice-presidents, Drs. C. H. Jones, S. C. Chew and J. L. McComas; recording secretary, Dr. J. F. Martinet; assistant recording secretary, Dr. C. E. Sadtler; corresponding secretary, Dr. Herbert Harlan; treasurer, Dr. G. L.Taneyhill; executive committee, Drs. B. B. Browne, J. E. Michael, T. B. Brune, R. B. Morison and H. P. C. Wilson. At the close of the business meeting, the annual banquet was enjoyed by a large number of the alumni, including the graduating class of 1886. One of the most appropriate exercises of the evening was the presentation by the class of 1886 of an engrossed series of resolutions, handsomely framed, as a testimonial to Prof. G. W. Miltenberger, on the occasion of the 50th anniversary of his connection with the University. Prof. Miltenberger replied in feeling and appropriate remarks to this act of generosity and kind feeling on the part of the graduating class.

Original Articles.

CIRCUMSCRIBED PERITONEAL DROPSY SIMULATING OVARIAN DROPSY.*

BY H. P. C. WILSON, M.D.

Surgeon to the Hospital for the Women of Maryland; Fellow of the American Gynæcological Society, and British Gynæcological Society· Member of the British Medical Association; Vice-President of the Baltimore Gynæcological and Obstetrical Society, etc., etc.

Mr. President and Gentlemen of the Academy of Medicine: I desire to call your attention this evening to a case of circumscribed abdominal dropsy, limited by peritoneal adhesions so complete, as to accurately simulate ovarian dropsy. It could not be called cystic dropsy, because the fluid was not contained in a distinct sac; but by adhesions from general peritonitis, the fluid was restricted to the front and lower part of the abdomen, and not allowed to gravitate throughout its whole extent. Change of the patient's position did not change the position of the fluid, and there was nothing in her history or symptoms to cause us to suspect a former, or recent, peritonitis. She had never been sick a day in her life, and all her organs were acting well.

Mrs. Jas. P., married, æt. 38. The mother of seven children—twins once, four miscarriages—four times delivered with forceps. Began to menstruate at 14. Noticed a swelling in the abdomen 1st of September 1885. Could not locate its beginning in either groin or lower abdomen. Has had regular menstruation always, except when pregnant.

She was sent to me by Dr. N. B. Baker, one of the most eminent physicians in Martinsburg, W. Va., with the statement that she had an ovarian tumor. I confirmed his diagnosis, when she was admitted to the Union Protestant Infirmary, February 12th, 1886.

She had a prominent fluctuating tumor of the lower abdomen. Dull on percussion to two inches above the umbilicus, dull in either groin, and presenting the characteristic, round and prominence of a cystic tumor of the ovary. Percussion was clear in both lumbar regions. Changing the patient's position did not change the lines of dulness anywhere. There was no tenderness over the abdomen to any amount of thumping or pressure.

The uterus was free in the pelvic cavity, and measured three inches by the sound. She had the facies ovariana. I had no doubt that the case before me was one of cystic disease of the ovary.

February 15th, at 2 P. M., was appointed for the operation; sponges, instruments, rubber cloths and dressings had been thoroughly carbolized. The carbolic spray had been going on in the operating room for one and a half hours, but was stopped before the operation began. Dr. N. B. Baker (whose patient she was) and Drs. Keyser, Faucett and Robert T. Wilson were present, with the two hospital nurses. The patient was given ʒi of whiskey, and chloroformed by Dr. Keyser. I again reviewed my former examination, and was satisfied that I had a simple cyst of the ovary, without complications, to deal with.

Not feeling well, nor in an operating humor, I handed the instruments to my son, Dr. Robert T. Wilson, and told him to proceed with the operation. He cut carefully into the abdominal cavity, making an incision of three inches, down to the peritoneum, and entering the cavity by an opening of about half an inch. Immediately, there was a gush of a greenish yellow fluid, and turning the patient on her side, about one and a half gallons escaped; enlarging this opening to three inches and looking in, a solid tumor was discovered about nine inches long, six inches broad and three inches thick. The walls of the abdominal cavity were festooned with recent lymph, and patches of the same were seen every where. The hand passed in, found adhesions every where. The uterus and ovaries were normal, but we could not determine by the touch and sight what this tumor was, till we had lifted it from the abdominal cavity, and found it was made up of coils of intes-

*Read before the Academy of Medicine, March 2d, 1886.

tine agglutinated with lymph. It was so firm and solid, that at first sight, it was hard to believe it a mass of intestines. It was not agglutinated to other abdominal viscera, but seemed to be free in the peritoneal fluid.

Dr. Robert Wilson returned the mass to the abdominal cavity, and closed the abdominal opening with seven silver wires, and dressed the wound as usual in ovariotomy.

Thus the case which I was sure was ovarian dropsy, turned out to be localized peritoneal dropsy, the result of peritonitis.

This woman told me before the operation, and has several times comfirmed her statement since, that she had never been sick a day in her life, except during confinements, and her youngest child is now two years old. Dr. Baker, who has been her physician ever since her marriage, assured me that her statement was correct.

For my diagnosis I had before me a fluctuating tumor, occupying the lower part of the abdominal cavity, and the abdomen was rounded prominently about the umbilicus. In the dorsal position, it did not bulge out to either side. There was clearness on percussion in both lumbar regions. Changing the position of the patient did not change the lines of dulness on percussion. She had no tenderness on abdominal pressure. All of her organs were acting well, and the pelvic viscera were as they should be in such a supposed ovarian cyst. No anasarca; no œdema of lower extremities.

I do not see how we were to avoid falling into the error into which we were lead. Had we tapped her (which should never be done in ovarian tumors if possible) we would have been none the wiser, but would rather have had our diagnosis confirmed by the solid tumor which would have remained. I have not implicit confidence in the ovarian cell as a means of diagnosis.

Dr. Peaslee says, in his book on ovarian tumors: "It might be expected that the removal of all the fluid from the peritoneal cavity would at once decide between ascites and an ovarian cyst. But Dr. McDowell and Dr. A. G. Smith had a patient, who had tapped herself with a trocar and canula, 90 times; in whom, on opening the abdominal cavity to remove an ovarian cyst, they found only a mass of intestines matted together by adhesions."

Dr. T. Spencer Wells, in his work on ovarian and uterine tumors, says: "The fluid poured out as the result of inflammation of the peritoneum, instead of lying free in the cavity, is sometimes confined in pouches formed by adhesions among the viscera, or by false membrane deposited during the disease, or by attachments of the omentum or mesentery." "The fluctuation, even if distinct, is always limited in extent and confined to the same spots. The intestines are found behind or beside the tumor, and do not as in ascites rise up to the front of the abdomen, or vary with the position of the patient."

Dr. West, in his work on diseases of women, says: "One instance of this latter occurrence has come under my own observation, in which between four and five quarts, of a *dark* fluid, were collected between folds of the omentum, and during the patient's lifetime, frequent discharges of a similar fluid had taken place from the umbilicus. The dropsy had during the life of the patient been supposed to be ovarian; but though malignant disease of both ovaries was discovered, yet neither of them contained fluid at all similar in character to that which was found in the omentum; nor, indeed, could either be detected till after the fluid in the omental cyst had been let out. I am aware of no means by which such cases are to be discriminated from ovarian dropsy. As far as I know, their nature has scarcely ever been suspected during the lifetime of the patient."

Dr. T. Spencer Wells reports a case in which he suspected ovarian dropsy. He carefully opened the abdominal cavity below the umbilicus. No cyst appeared. A large quantity of opalescent fluid escaped. The whole peritoneum was studded with tubercles. Some coils of small intestines were floating, but the great mass was bound down with the

colon and omentum, towards the back and upper part of the abdomen. She went through a sharp attack of peritonitis, but recovered, and has been well ever since the operation. No more fluid was secreted, and the patient regained health and strength, and married. The operation was done in 1862, and Mr. Wells reports the woman well in 1881.

I might report many other cases of circumscribed peritoneal dropsy, so simulating ovarian dropsy, as to lead to an erroneous diagnosis which was only rectified by an exploratory incision, or a post-mortem examination, but I will not weary you further.

The greater my experience, the more I am impressed with the propriety of such incisions, in all cases of abdominal tumors, where life is involved. I am convinced that many more lives are lost for the want of such incisions, than on account of them.

To Dr. Robert T. Wilson I am indebted for the following history, as well as the treatment of the case subsequent to the operation.

First day, 15th February, 9 P. M.—Temperature 103, pulse 120, respiration 22. Abdomen distended. All dressings were removed, and the abdomen covered with cloths, wrung out of cold water, to be renewed every few minutes throughout the night. Pulse feeble. Gave 10 drops of tincture digitalis every two hours and a teaspoonful of very hot water occasionally. At 9.35 P. M. she was given 20 minims of muriate of quinia and urea, hypodermically, and ordered half an ounce of milk every two hours. At 10 P. M. she was becoming restless, and was given 10 m. of Magendie's solution of morphia under the skin.

Second day, 16th February 7.30 A. M.—Temperatune 101⅘, pulse 100, respiration 20. Had a good night. Took nourishment well. Passed urine and also flatus freely. Had no nausea or pain. Tongue dry. Gave hypodermically 7 m. of Magendie's solution. Digitalis, cold applications to abdomen, and milk continued. A teaspoonful of whiskey was added to each portion of milk.

1 P. M.—Temperature 100¾, pulse 92, respiration 20. Tympanites great, but continues to pass flatus freely. Urinates freely. Bears her milk, whiskey and digitalis well. Treatment continued as before.

4.30 P. M.—Temp. 101⅘, Pulse 104, respiration 24. Pulse stronger. Tympanites increased. No unusual tenderness after such an incision. No pain. Is calm and comfortable. At 3.45 vomited for the first time. She attributed it to the whiskey, which was always disgusting to her. So it was stopped by the mouth and ʒ ij. were given per rectum every six hours. ʒ j. of milk and ʒ ij. of lime water were given by the mouth every two hours. Cold water dressings and digitalis continued as before. Tongue still dry.

Third day, 17th February, 8 A. M.—Temperature 98, pulse 100, respiration 20. Pulse stronger. She passed a comfortable night. Had no nausea nor vomiting. No pain. Passed urine and flatus. Took nourishment well. All treatment continued as yesterday.

3.45 P. M.—Temperature 98⅘, pulse 112, respiration 20. Has had two liquid evacuations, passing urine and much flatus at the same time. Stopped whiskey enemas, and gave 25 drops of laudanum in an ounce of starch water, ordering the same to be repeated after each evacuation; she required no more. This enema, and the two small hypodermics of morphia, reported above, is all the opium given in this case. ʒ ij. of sherry wine, every three hours, by the mouth, were ordered, as she thought she would relish it; but it was soon discontinued as it became distasteful. Tympanites still great. Milk and lime water, digitalis and cold water dressings continued. Tongue more moist.

Fourth day, 18th February, 9.30 A. M.—Sleeping. Pulse 100, respiration 18. Had a good night, and bore her nourishment and medication well.

5 P. M.—Temp. 99, pulse 100, respiration 20. Has passed much flatus. Abdomen soft and bears pressure well. Abdominal wound united by first intention. She expresses herself as very comfortable. Treatment continued.

Fifth day, 19th February.—Temp. 98⅘, pulse 100, respiration 20. Doing well. Tongue moist. Abdomen soft. Taking ʒ ij. of milk every two hours, with lime-water. Treatment continued.

Sixth day, 20th February.—Temp. 98⅘, pulse 100, respiration 20. Doing well, and treatment continued.

Eighth day, 22nd February.—Temp. 100⅕, pulse 100, respiration 20. A small abscess opened along one of the wires which no doubt sent up her temperature. Abdomen soft and no tenderness. Tongue moist. Appetite ravenous. Wants "middling and greens." She is now allowed all the milk she wants. A soft boiled egg for breakfast, and good soup for dinner. She had some sweating last night, and was ordered 3 j. of infusion of cinchona bark, with 25 drops of aromatic sulphuric acid in it, three times daily. She is bright and cheerful and jokey, and expresses herself as feeling very well. The digitalis was stopped.

Sixteenth day, March 2nd.—The patient has had no unpleasant symptoms since last report, except the formation of several abscesses along the wires. They united and caused a superficial gaping of the abdominal incision. This is rapidly closing by granulation. She looks much improved since the operation. Appetite good; sleeps well; bowels regular; is cheerful and bright, and out of all danger.

Injections into the Lungs.—A discussion has recently taken place in the Medical Society of the Paris Hospitals, chiefly between M. Gougenheim and M. Dieulafoy, on the advantage of practising antiseptic injections into the tissues of the lungs in cases of phthisis. M. Gougenheim had injected bichloride of mercury in thirty-three cases of advanced phthisis with considerable amelioration, the loss of flesh being retarded and the râles as also the expectoration diminished. M. Dieulafoy, on the other hand, had in 1881 practised injections of glycerine of carbolic acid, coloring this with cochineal, by which means he was able to assure himself by inspection of the sputa that the antiseptic had entered a cavity. He found, however, that the patients suffered great pain from the injections, and that no beneficial effects followed, so that he soon abandoned this treatment.—*London Lancet*, January 30th, 1886.

A CASE OF OVARIOTOMY WITH SUPRA-VAGINAL AMPUTATION OF THE UTERUS.*

BY WILLIAM PAWSON CHUNN, M.D.,

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In perusing the history of the following case we meet with several points which are interesting. A woman with an enormously distended abdomen not due to ascites is always an object of curiosity to one who has seen something of these cases. In an unusual case where the diagnosis is gradually narrowed down to a selection between a very large unilocular ovarian cyst and a fibro-cyst of the uterus, the interest taken is still greater, and when, in addition, such a patient has the physical signs and history which would apply to either diagnosis, added to an African decent, we have in hand a case that calls for diagnosis as well as treatment. Such a case was referred to me through the kindness of my friend Dr. Charles Mitchell, of this city, and the diagnosis and subsequent treatment of this patient is the reason for my presenting these lines to the Society to-night. Upon first seeing the patient I was struck by the very large size of the abdomen, and upon enquiry elicited the following history. She was a mulatto, was rather dark in color and might consequently be called a negress, although not coal black. She was 20 years of age, the mother of one child, 6 years old; had suffered no miscarriages. About three years before I saw her she had noticed that her abdomen was gradually enlarging, symmetrically, from below upwards, until it had attained its greatest size. Her menstrual flow had been regular in regard to time, but slightly exaggerated at some of the periods. She measured fifty inches in circumference around the largest part of the abdomen, and the tumor was prominent and projected the abdominal walls decidedly forward. Palpation showed fluctuation very plainly in all directions. Percussion gave flatness all over the abdomen except high up over the trans-

*Read before the Gynecological and Obstetrical Society of Baltimore, March 9th, 1886.

verse colon and stomach, and to a slight extent in the flanks where there was resonance. I also discovered fluctuation, showing ascites to be present. Vaginal examination being practiced showed that the tumor did not project into Douglass's pouch, but on the contrary had carried the pelvic floor aloft with it in such a manner that the pouch was obliterated. The vagina was so pulled up in the pelvis that the cervix could not be felt by the examining finger, but the position of the uterus was readily determined by palpation, to be high up on the anterior aspect of the growth about an inch below the umbilicus. Every motion imparted to the tumor gave a similar impulse to the uterus. Owing to the position of this organ it was impossible to make use of the uterine sound. Knowing how rare ovarian disease is among the African race, and bearing in mind the physical signs presented, I was inclined to think that I had a case of fibro-cyst of the uterus to deal with. A number of other gentlemen saw the case with me, and, with one exception, confirmed the diagnosis. Prof. Wm. T. Howard, however, thought differently and pronounced it ovarian, saying that although fibroids were very frequent in the African race, fibro-cysts were as seldom met with as ovarian cysts, and moreover as he had never heard of a fibro-cyst under 27 years of age, he was opposed to the diagnosis of ovarian disease. The literature on the subject proved scant. Thomas, Emmet, Barnes, Courty, Edis, Tait and Wells, do not mention having seen ovarian dropsy in the colored race. As the patient was rapidly going down hill, it was evident that if her life was to be saved something would have to be done speedily. Her urine being examined was found to contain albumen and all sorts of tube casts in the utmost profusion. However, I decided to do an exploratory incision at any rate, and afterwards be guided by circumstances, being prepared to do hysterectomy if necessary.

On December 22d, the patient was etherized and the usual incision made in the linea alba. With a few strokes of the knife the peritoneum was opened and a glistening pearl colored cyst came into view. The appearance of the growth showed its ovarian origin. The patient was then turned on the side and about a quart of ascitic fluid was allowed to drain away. The cyst was then tapped with a large Well's trocar and three or four pails full of a dark chocolate colored fluid withdrawn. As the fluid drained away the sac was pulled through the abdominal incision, the hand having been introduced into its interior to break down smaller cysts. As the sac emerged still further, two large attachments to the omentum had to be separated and tied with silk. Both of the ligatures were returned into the abdomen after being cut short. Steady traction being now made the lower part of the sac was delivered through the abdominal wound and with it also came the uterus. This organ, as was diagnosticated before the operation, was found six inches above the pubes, imbedded in the anterior wall of the sac. The left side was covered by the broad ligament, which embraced also the lower part of the cyst on that side. On the right lateral border the uterus was free from attachments, but the posterior aspect was imbedded in the cyst wall in a sort of bas-relief fashion. So then it was seen that the uterus was firmly attached by all of its left side at the fundus, and by its posterior aspect. This appearance led me to decide that it would be impossible for me to separate the uterus from the cyst wall, and so I decided to clamp the cervix and pedicle of the sac as low down as possible and trust to the extra-peritoneal method of treatment.

With this idea in view the cyst was pulled through the abdominal wound, and Dr. H. P. C. Wilson kindly adjusted his chain clamp around the pedicle, while I supported the parts, the chain being so manipulated as to embrace the cervix about the vaginal junction, together with lower part of the ovarian sac, nearly all of which could be pulled up into the bite of the chain. The left broad ligament was also included as it encircled the lower segment of the tumor on the left side. Fearing that by

some chance the bladder might be included in the clamp, I had a sound passed before the chain was tightened, but the sound in the bladder seemed to show that so far from the bladder being grasped by the clamp, it was really nowhere near it. Every thing being now in readiness the chain was tightened up and the tumor rapidly cut away along with the uterus about the vaginal junction. The stump was then adjusted in the lower angle of the wound, the upper portion of the cervical canal cut out and cauterized, and the over-lapping part of the stump closely trimmed off. As some of the ovarian fluid had unavoidly escaped into the abdomen a Davidson's syringe was used to thoroughly wash the peritoneum. It was found impossible to get all the fluid out of the peritoneal cavity, so after repeated spongings a drainage tube was put in the wound just above the stump and the incision sewed up with seven or eight silk sutures. The small number of ligatures used was due to the thickness of the stump which filled up a good deal of the lower part of the abdominal opening. Per sulphate of iron was used to tan the parts projecting above the clamp, and iodoform being plentifully sprinkled over the parts, the usual dressing was applied and the patient put to bed. Time of operation one hour and thirty-five minutes. Pulse 120; temperature 98½ (December 22d).

December 23rd, the day succeding the operation, at 7 o'clock in the morning, the pulse was 150, temt. 101. In the evening of the same day pulse and temperature were the same as in the morning. At night, however, the pulse beat a hundred and sixty to the minute, with a temperature of 102. The patient seemed bright and fully conscious. On the third day the pulse under digitalis (30 gtts.) came down to 120, and I began to be more hopeful. There was no nausea at any time, and at 6 o'clock in the evening flatus was passed by the rectum, giving considerable relief. All the while a great deal of serum was coming away through the drainage tube, but as this discharge ceased on the fifth day after the operation it was withdrawn, and the opening closed by a suture, which had been before introduced for that purpose. The pulse and temperature, however, remained rather high (pulse 126, temp. 102½), and on the eighth day fluid was detected in the lower part of the pelvis, and fluctuation finally became evident. The position of the fluid was just in front, above and a little to the right side of the remains of the cervix, and caused the abdomen to project just as if the bladder was distended with urine. As the fluid was evidently just beneath the abdominal walls, and as there was great danger of wounding the bladder or ureters by an incision through the anterior wall of the vagina, I decided, with the assistance of Dr. H. P. C. Wilson, to do a second laparotomy. The patient refused any anæsthetic, and consequently I operated without any. An incision was made in the median line about three inches above the symphysis, and the tissues divided layer by layer until the peritoneum was reached. This membrane being finally divided upon a director a quick gush of foul serum found vent, and the swelling immediately disappeared. A Davidson's syringe was introduced into the cavity, with a view to wash out the whole lower part of the abdomen, but the water was almost immediately returned, showing that the cavity I had to deal with was a shut sac. A drainage tube was left in place, and the abscess was washed out three times daily, after which it gave no further trouble. The pulse and temperature at once came down as a result of treatment. About the seventh or eighth day after operation a clear fluid was noticed to wet the bandage, and to be continually dribbling away from the abdominal wound. This secretion had the odor of urine, and careful examination afterwards proved it to be such. On January 1st, 1886, the temp. rose, and in the morning the thermometer registered 104⅗, or between that and 105. This temperature kept up for three days off and on. At times by sponging and the hypodermic use of quinia and urea I could reduce it to 103. On the morning of the third of January the temp. stood at 104⅗. I then gave 3 ss. of antipyrin

at one dose, and on coming back in the afternoon at 3 o'clock found the temp. had come down to 102. The pulse was full and regular at 110. I had no more trouble with the temperature after this, as 20 or 30 grains of antipyrin would always reduce it to 100 or 101. The pulse would also become stronger, and less frequent. This treatment was tried and always with the same result. The high temperature was in part due to a pelvic peritonitis which became developed in Douglass's cul-de-sac later on. As this mass behind the posterior wall of the vagina become soft and œdematous, I resolved also to make an incision into the posterior vaginal wall. The patient being lifted on a table, and fortified with a good drink of whiskey, was placed on her back, and in this position I stuck a sharp-pointed bistoury into the swelling, and was rewarded by a slight quantity of serum. The swelling, however, did not materially disappear, as much of it was due to inflammatory infiltration in the cellular tissues. This inflammatory attack kept the temp. and pulse somewhat elevated, and affairs progressed as in any ordinary case of pelvic peritonitis. On the 5th of February a small pelvic abscess burst into the abdominal wound, and afterward convalescence rapidly ensued. The patient went on then to an entire recovery, and is now perfectly well. The clamp came away on the 13th day after operation, but the stump had to be trimmed frequently afterwards, and great care was necessary to keep the part aseptic. The pedicle in the beginning was hard and leathery, but as pus welled up around it from the healing of the wound it became quite offensive. Among the questions that might be asked as bearing on the case is the query: what became of the other ovary? To this question I am free to confess I do not know, as I neither saw nor felt it during my manipulation about the tumor, nor while I had my hand in the pelvic cavity. Other operators have left an ovary behind with no bad result, and I did not feel at liberty to enlarge the incision, to hunt up an organ which would never be of further use. Since the operation she had passed over three menstrual periods, with no disturbance of any kind, and without any flow of blood from any organ, and I see no reason why this condition of things may not continue. The discharge of urine from the wound about the 5th day inclined me to believe that I had included one of the ureters in the clamp, as I have already stated, but I was lead to change my mind by the following facts: If the ureter had been included, what would have become of the urine that should have been excreted from that ureter during five days? And again, later on, when the patient began to get about, owing to the upright position, not near as much urine drained away, as did while lying down ; and, moreover, when she was up, and emptied her bladder frequently still less discharge was noticed than ever before. I believe Prof. Simon, of Germany, had a case somewhat similar, where the ureter was tied, and afterwards gave rise to an urinary fistula. He did a second operation, and cured his patient by taking out the corresponding kidney. If only the bladder is constricted, it seems to me that it would prove comparatively easy to open the abdomen and separate the bladder from the adhesion to the cicatrix, and thus close the fistula. As in time the stump will settle deeper and deeper in the pelvis it may come to pass that the attachments between the bladder and the abdominal wall may become so attenuated that the fistula will be obliterated. Another point of interest about brings the history to a conclusion. Before the operation the urine was examined and found to be full of albumen and tube casts in the utmost profusion. I looked upon this condition as merely the results of pressure and malnutrition superinduced by the abdominal tumor, and another examination two months after the operation confirmed the correctness of this view, as the urine was then without albumen or tube casts of any kind and only showed some oxalate of lime crystals. So far then from regarding casts and albumen in the urine as a contra indication for operation, I think the operation in large tumors should be looked upon as the only means of re-

lieving that condition. If I mistake not a certain operator on the Continent did a hysterectomy and for some good reason left one of the ovaries behind. The woman recovered, conceived again, had an abdominal pregnancy, and was delivered by laparotomy. This case caused me to consider the advisability of entirely closing up the cervix by Emmet's operation and thus prevent possible accident. In closing, if I may be allowed to mention the idea most forcibly impressed upon my mind by this history, I would say that while the extra-peritoneal method of dealing with the stump may be unavoidable at times, it gives rise to grave accidents, which a secure intra-peritoneal method does not engender and that it will not be the method of the future-

AN ADDRESS DELIVERED BEFORE THE GRADUATING CLASS OF THE UNIVERSITY OF MARYLAND, MARCH 17, 1886.

BY WM. ALLEN, A.M.,

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One of the greatest English scientists, in a recent sketch of the illustrious Frenchman whose past discoveries have won the admiration, as his present investigations engage the attention of the scientific world, says:

"Never before, during the long period of its history did a day like the present dawn upon the science and art of medicine. Indeed, previous to the discoveries of recent times, medicine was not a science, but a collection of empirical rules dependant for their interpretation and application upon the sagacity of the physician." Nor, does it appear to me that Tyndall is at all too enthusiastic in his anticipations of the glorious day in the history of medicine, the dawn of which already falls upon him. You stand at the threshold of this day, gentlemen, and in its work you are to participate. You have peered forth into it, no doubt, from a professional standpoint, and tried to measure its capabilities and possibilities as a field for life work. But it may be of interest to you to take some glimpses at the future of your profession through the eye of a layman, to know what of promise the coming time seems to hold out to the worshippers about the altar—aye, even to the possible victims upon it—as well as to you whose high duty and privilege it is to minister at its sacred fires.

The progress of the age, the immense intellectual and material advance which has been made since the days of our grandfathers is so trite a theme that its very familiarity dulls our appreciation of the truth. We do not realize, for instance, the change which steam and electricity have introduced not only in the means of intercommunication, the extension of manufactures and the diffusion of knowledge; but in all the habits and modes of thought of modern life. Not only are great physical problems daily met and conquered, but changes are going on which affect the whole structure of society, which call for new departments of law, which require a readjustment of the relations between the different classes of mankind, and have seriously modified our ideas of government itself. These vast changes—themselves the result of science—have not kept pace however with the progress of science itself, with that intellectual activity and power which has produced them, and which in every direction has added conquests so splendid to the domain of human knowledge. Even long worked mines of knowledge, like astronomy, have yielded during the present century returns far transcending all former periods, while whole groups of new sciences like geology have been dug from heretofore unexplored veins. In this advance the sciences included under the name of medicine have had their full share. Probably no other branch of knowledge can show more wonderful discoveries, certainly no other can show so great direct results in bettering the condition of mankind. It is estimated that the average duration of human life has been extended seven years in the last two centuries, and the greater part of this is to be credited to the advance of medicine

in the latter half of that period. In the last fifty years surgery has been, we may say remodeled, revolutionized, and the numberless skillful appliances by which human misfortune is palliated or neutralized in this day would astonish our grandfathers as much as the telephone. Nor less so the many instruments by which the difficulty of diagnosis is greatly lessened in some of the most wide-spread of diseases. Who, too, can estimate the sum of the suffering which has been saved by the introduction of anæsthetics? How many thousands of those racked with wounds or disease have felt or exclaimed as did Stonewall Jackson when passing under the influence of chloroform, before the amputation of his arm, "What an infinite blessing! What an infinite blessing!" And the theory of zymotic diseases, how great its extension and wonderful its development of recent years. Here the microscope has opened up new worlds for conquest. The lenses which not long ago were little more than a toy have become in the hands of Koch, of Pasteur, and of a great multitude of their co-laborers a wand more mighty than the Arabian's for revealing the secrets of the universe. The great discovery of Jenner—one of the most beneficent that ever rewarded human sagacity—stood for years alone in its splendid results; but the microscopic investigations of our day, guided by the genius of a Pasteur, seem about to multiply indefinitely man's curative power over some of the most terrible "ills that flesh is heir to." Or turning in another direction how well does that great humorist, as well as physician, Dr. O. W. Holmes, portray the advance which dentistry has made, when he says: "Think of poor King David, a worn-out man at 70, probably without teeth, certainly without spectacles. Think of poor Geo. Washington, his teeth always ready to drop like a portcullis, and cut a sentence in two. See him in Stuart's admirable portrait, his thoughts evidently divided between the cares of empire and the maintenance of the *status quo* of his terrific dental arrangements."

The conquests which medicine has recently made as well as the activity with which it is in every direction attacking the unknown must be taken into view in forming your plan of professional life-work.

It is no longer possible to consider medicine as a mere collection of empirical rules, a trade spiced with magic. No, gentlemen, you are not to be the priests of a superstitious cult, to minister at altars dedicated to unknown mysteries, you are not to be blind leaders of the blind, relying for your influence on the ignorance and the fears of mankind. On the contrary you are entering upon the prosecution of one of the noblest, most progressive, and most fascinating of the sciences, and your plan of work should be such as becomes the object in view. You have been fortunate in your opportunities for preparation. You have not only had "line upon line, precept upon precept." You have had more. You have had constantly before you eminent examples to point the way to professional success. Your Alma Mater crowns you with honors and bids you God speed. She has carried you to a hilltop and directed your vision to the unexplored land, pointing out the roads which lead to its various parts, and told you how best to travel these roads. This if you are wise to profit by it is much; but is all that she can do. Even your professional studies have so far been merely preliminary. A more important lesson than any you have had will come to you with the first patient, when you will have not only to investigate for yourselves a problem perhaps intricate and difficult, but may have to decide promptly and upon your own responsibility the issues of life and death. You will need to be painstaking, accurate workers. If you would grow, remember that growth is more the product of your own experience, carefully studied, and collated with that of others, than of aught else. The ordinary country practitioner of two generations ago with lancet and bundle of powerful drugs in his saddle-bags, the very embodiment of conservatism, rarely deviating from the rules he had learned at college, seldom reading anything less venerable and well-established than his former text-books, regarding all new

ideas in medicine with as much horror as the orthodox theologian of that day did a new dogma, curing or killing as the case might be, but always in strictly orthodox fashion,—was often a useful man in his time, a valuable member of society, though sometimes guilty of involuntary manslaughter. But he cannot be reproduced with success in our day. He must be replaced by a figure ever on the alert to learn, avoiding ruts, observing with eager and intelligent interest every case of disease that comes before him, well informed as to what others are doing, and always willing to learn from their experience. If such an ideal seems to you not easily nor quickly to be reached, remember that human character is not a matter of sudden construction like a block of buildings, but is a slow and steady growth like a great tree. One of the most striking passages in the charming autobiography of Dr. Marion Sims is the account he gives of his first two patients—two babies—to one of whom he administered all the remedies laid down in his books in regular order. Finding these were unavailing, and not knowing what better to do he tried the same remedies on the next baby, but in inverse order. How vividly he describes his real ignorance and helplessness in the presence of the problem before him, how keenly he felt that even the old nurse knew more about the dying child than he did. How humbled he was by the kindly patronage of the old consulting physician, and how strong was the sense of responsibility when he realized that he had done nothing for the children unless it was to expedite their journey to a better world. He pulled down his shingle, threw it into a well and moved away to another State to begin work over again. But in this keen perception of the situation and of his own shortcomings lay the elements of greatness. This instructive incident was the beginning of a splendid career, the first step towards that fame which has become the joint tribute of two continents.

If the requirements of your profession on the scientific side are high the attractions it offers from the same standpoint are great. Sir James Paget says in effect that as a calling medicine offers the most complete and constant union of those three qualities which have the greatest charm for pure and active minds—novelty, utility and charity. For in every search for truth we cannot only exercise curiosity and have the delight of watching the unveiling of a mystery, but on the way to that truth, if we look well around us, we shall see that we are passing among wonders more than eye or mind can fully comprehend. Nor is the truth sought for of remote interest. It has immediate practical utility. And this utility is not selfish. The investigations and discoveries of the physician are for the good of the race. Their object is the alleviation of human suffering, the promotion of the comfort and happiness of others. So simple and comprehensive a view of medical work needs no addition, but if I may venture to add to the words of so great an authority, I would suggest as additional advantages, that the data for investigation are always at hand, and that they are among the most fascinating objects of human study. For they are the phenomena of life, of that mysterious something which is everywhere in the material world, and not of it, which with more than a wizard's power tranforms dead matter into living, breathing forms of grace and beauty, which whenever found in earth, or sea, or air, breaks with majestic and resistless force the bonds in which dead atoms have lain at rest mayhap for ages, forces them into new relationships, and builds from them living creatures infinitely varied in nature, form and function.

But, gentlemen, medicine in becoming a great science, has not ceased to be an art. On the contrary it never before demanded an eye and ear so keen, so accurate, a touch so delicate, and hand so well trained and skillful. The instruments of precision by which the different organs of the body are tested, and those marvellous devices by which operations are performed on the internal organs, which a few centuries ago would have been deemed miraculous, as well as all the ingenious contrivances of dental surgery, require for their successful use a manual practice and training heretofore

unapproached. The science of the young practitioner is often rendered worthless from want of familiarity with his tools. You all remember the story which Dr. O. W. Holmes tells in his stethoscope song of how the young doctor just from Paris was cheated in his diagnosis by a spider and a couple of impudent flies. In his first patient they led him to discover amphoric buzzing. Of his next—poor old lady—it is said:

Now when the stethoscope came out,
The flies began to buzz and whiz;
O ho! the matter is clear no doubt,
An aneurism there plainly is.

Now when the neighboring doctors found
A case so rare had been descried,
They every day her ribs did pound
In squads of twenty—so she died.

In this case, as in others, however, experience finally brought wisdom, for

The doctors being very sore,
A stethoscope they did devise,
That had a rammer to clear the bore
With a knob at the end to kill the flies.

Only ability far above the average, backed by an enthusiasm and a capability for work equally unusual, may hope to cultivate the whole field of medical science and art. But the division of labor, the differentiation of work which characterizes the age renders such an attempt unnecessary. The tendency to break up the practice into specialties is yearly becoming stronger. Even the general practitioner has a much narrower field than formerly. This tendency has its evils, great evils sometimes, but they are less than those which result from two great a diffusion of effort. The world demands thorough rather than extensive work and thorough work is possible only in a limited field. The surroundings of your future will determine for each of you the line of work you are to follow. What that line is makes no great difference, but it makes all the difference in the world how you pursue it. To the general practitioner (the career to which most of you will look at first), along with the opportunities for a broader and more symmetrical development comes the greater danger of drifting into routine. He finds that he cannot push his advance in a number of directions, and too often he becomes content to do it none. You should guard against this danger. The young practitioner can always select if he will something in his field of work, and make a specialty of that for his own training, if for nothing else. However narrow this special line of investigation may be, if it be prosecuted in the true scientific spirit, the effect upon his intellectual growth and professional development in other directions will be great. It will not merely give tone and life to all his work, but it will confirm right habits of observation and of thinking without which real progress is impossible.

So far we have considered medicine in itself, its immensely extended scope, its systematic character, the charm its pursuit presents, the high demands it makes upon its votaries. Let us glance for a moment at some of the more public and social aspects of your profession. No department of it has produced more wide-spread or tangible results than that of sanitary science. If railroads have rendered possible an extension of the number and size of large cities such as was never seen before, sanitary science demands far more our gratitude for having immensely diminished disease and death which were accustomed to run riot in these crowded centres. When the Gods met to determine whether Poseidon or Athene should give name to the city which was to be the centre of Greek culture and Greek influence, it was decided that this privilege should go to the one that should bestow the best gift upon the sons of men. Poseidon brought forth the horse and claimed the prize, but when Athene presented the olive tree, the sign of peace and plenty, a universal shout awarded her the palm and Athens thence-forth bore her name.

And so to-day the gift of health and the happiness that follows, far outweigh the value of the iron horse.

In how many ways has medical investigation promoted the public welfare. No longer is the health of great cities endangered by impure water—at least without their knowing it—no longer are the subtle poisons of sewage permitted

to destroy at will without detection or prevention, no longer is the air we breathe, the fuel we burn, the food we eat, the unchallenged vehicles of disease and death. No, everywhere has medicine set itself aggressively and with a wonderful success to check the destroyer. It has pointed out his strongholds, it has laid bare his secrets, it has taught mankind to circumscribe and control enemies of life as powerful as dynamite and as subtile as electricity. Nor does it pause in its labors. It is constantly attacking new problems of sanitation or more thoroughly solving old ones; it is constantly devising new means of defence against the plagues which were once the terror and the curse of men as well as warning them of the dangers which lurk in the changes and improvements in our modern modes of living. This line of investigation is by no means exhausted. None know so well as physicians how much yet remains to be done and your generation, gentlemen, must carry forward on a growing scale this beneficent work.

Not less important than the investigation of sanitary science is the diffusion of the knowledge thus obtained and the creation of an enlightened public sentiment which will ensure the wise use of all means within reach for the promotion of the public health. The general knowledge on this subject seems to me to be much below the standard which the medical profession might set up. Wretched systems of sewage, bad water supplys, poorly ventilated buildings, all kinds of poisoned foods yet abound. It has been only a few years since the hall of the House of Representatives at Washington was considered, from bad ventilation, unsafe for occupation for any length of time; and for years Philadelphia, one of the centres of medical science in this country, has endured a water supply unfit for use. Engineering with all its great triumphs has hardly been able to keep pace with the advance of sanitary knowledge and the requirements of that knowledge, and public sentiment has not demanded that all the resources of engineering should be put forth. All this follows from the slowness with which knowledge in regard to the conditions on which depend the public health, spreads through the community. The mass of people appreciate too feebly the importance of questions of sanitation. In many places there is a sort of hazy conviction that an ounce of prevention is worth a pound of cure, but there is no clear idea as to what this prevention should consist of, or how, when, and where it should be applied. Other places, instead of putting a shoulder to the wheel, call upon Providence to deliver them, as in the old fable the wagoner did upon Hercules. One of the most useful labors of the medical profession in your day, gentlemen, will be to improve this state of things by the constant and persistent dissemination of information. It will be your duty to educate the public to a realization of how much may yet be done for the promotion of the general health, for counteracting the effects of filth and poverty, and for limiting the spread of epidemics. It properly belong to the medical profession to guide the legislation, municipal and state, which has these objects in view. That such legislation may be intelligent and effective it must proceed from the demands of an enlightened community and it must be shaped by men conversant with the results to be sought and the best practicable methods of attaining them.

And here, gentlemen, will you pardon me a word in favor of a broader and more generous diffusion in our daily life, and in your daily practice of the light which your profession throws upon the pathways of life. The theory of evolution, the splendid achievement of one of the greatest men of our day, of one too who began life by the study of medicine, speaks of the remains of disused or superseded organs which are found in many living creatures—the traces of a a past life that now serve no other purpose than to point out the course of development. Your profession, which goes back to a hoary antiquity, seems to me to carry along with it in its new and larger life occasional traces of its former existence. May I venture to suggest that the evolutionist might find in the

mysterious silence—or if you prefer, in the modest reticence—of the profession of to-day a trace of the era when medicine was far less a science than an awe-inspiring mystery, which kept Sphinx-like guard over the secrets it did not comprehend. Not to so remote a time belongs the custom of Latin prescriptions which like Latin laws and Latin liturgies must pass away. The abolition of these (Latin prescriptions), if it had no other good effect would lead to as large an economy of swearing as did Mark Twain's scrapbook. May we not find some relics too of the past in the rules of that professional etiquette which is so rigid as to be sometimes disastrous, which occasionally paralizes tongue and hand in the very presence of death, which makes the succoring of human ills dependant on a code the punctillios of which are frequently violated only through ignorance or grief. Our political leaders think that a convention to revise the organic law ought to be called once in every twenty years or so, and they fill up all the intervening time with annual measures of reform. While not hoping to reach this lofty standard of zeal would it not be well for the doctors to have a constitutional convention to recast their rules once in a century? But to return to the main point, the desirability of spreading wider a knowledge of the human body and of the laws of health. Until comparatively recent years all this was omitted from our systems of general education. Well trained men and women knew no more of the machinery of their bodies and of how to keep it in good order than they did of Chinese. How many cases have we seen of men profoundly versed in various branches of learning who have failed to live out half their days from lack of an elementery knowledge of the conditions of their own existence. With all their ancient lore or modern science they have wrecked health and life on an ignorantly maltreated heart, or lungs, or liver. Much has been done of late to correct this omission. Courses of Anatomy, Physiology and Hygiene are to be found in many good schools, but the reform has been by no means so extensive as it ought to be. Some knowledge of these subjects should be placed so far as universality of requirement is concerned, along side of the three R's. They should not be optional but required parts of every curriculum. An average school boy should no longer know more of the geography of the earth or perhaps of the sky than of his own body; should not be able to detect violations of the rules of syntax more readily than of the laws of his own health. Your voice can aid or retard this reform. You can do more. Instead of the silent, mysterious wonder worker, you can act in your daily life the part of a teacher, letting the light in upon the domains of ignorance and superstition, diffusing true knowledge among all you meet, gradually educating the community in which you work to an intelligent conception of the laws of their own physical well-being. For the improvement that has been already wrought we owe much to the medical profession; for the larger improvement which I am persuaded is to come we shall owe it still more.

Much of what I have said may have a far-away sound to young doctors at the outset of their career to whom the necessity of bread-winning overshadows all else for the time. You have chosen your line of work, you wish to enter at once upon it and to secure its rewards. Do not be frightened by the fears of an over crowded profession. Gentlemen, all professions are over crowded if we judge by the men who fail in them or by the struggle for existence that is everywhere going on. This day there is as much overcrowding in the corn and wheat fields of the country as in the shops, the counting houses, the professions of the town. Earnest, systematic, faithful, intelligent work is demanded everywhere, in medicine as in all things else—the other sort of work of which there is too much in the world is at a discount. As an eminent physician recently put it: There is plenty of room at the top and not only at the extreme top but anywhere in the top half of the army of doctors. It is only those near the bottom that are crushed and suffocated by the superincumbent mass.

Do not try to creep into success through some crevice; strike out boldly and carve your way forward. With a good education, and a sound digestion there is needed but a fair amount of common sense and a good deal of grit to ensure success. If you want business show that you means business. If you expect people to entrust their health and lives to you, show by your carefulness, your zeal, your devotion night and day to your duty that you are worthy of so great a responsibility. Watch and fight disease in the case of a patient with the sleepless energy you would use in your own case. Sir Henry Holland, who is certainly entitled to speak on this subject, has said: "That actual experience with a sense of responsibility attached to it is the sole school in which to make a good physician."

But gentlemen, even at the start, do not look upon your profession only as a means of bread-winning. Soldiers have sometimes stormed a camp for the sake of the plunder to be found in it and so there are soldiers in the battle of life who have no higher incentive; but these are not the men who win permanent or satisfactory success.

Your horizon must be broader to ensure even sordid gains. This horizon should take in something of the glories of the day whose dawn is upon you, of the splendid fields for intellectual research to which the labors of the great physicians of the past and present age point you; of the large opportunities which the progress of surgery offers for skill and ingenuity; of the openings which sanitary science and the diffusion of medical knowledge give for usefulness to society.

A narrow and selfish conception of your life-work will not fit you to guide childhood into healthy youth, and youth into vigorous manhood, by the rational use of our powers and the avoidance of the pitfalls set by ignorance and growing appetite; nor to stand beside the bed of pain and minister not merely to the suffering flesh but to burdened minds and anxious hearts; nor to carry in your bosom the secret of many a life—a sacred charge committed to you only that you may replace pain with peace, misery with happiness; nor to enter the most sacred precincts of home as trusted counsellor and confidential friend to whom the life and heart are laid open more fully than even to pastor or priest. Apart from its attraction as a science and an art no human avocation is better fitted than yours, gentlemen, to call into action all that is highest and best in humanity, but this it can do only when head and heart are responsive to the needs, the weaknesses, the sorrows of others no less than to the interests of self; when something of the courage of the soldier and the spirit of the good Samaritan strengthen and glorify the life.

I wish you, God speed in the grand and inspiring career you have chosen. And when a half century hence some one—perhaps the tottering survivor of those whom I now address—shall tell over the names and careers of this class, may it be said of each of you, as of the Hebrew soldier, prince, and poet. "He served his generation."*

*[NOTE.—The name and tittle of the author of this address should read WM. ALLAN, A. M., LL.D.]

Correspondence.

TREATMENT OF FURUNCULOSIS.

BALTIMORE, March 15, 1886.

Editor of Maryland Medical Journal.

DEAR SIR:—For the treatment of furunculosis about the face, I have found the following treatment to give the best results, particularly if taken in the early stage.

Sulph. Calcis	-	grs. iv.
M. fit pil. No. viii.		

One or two pills at night, according to the severity of the case, for several nights.

Fomenting the affected parts with

Ext. papav. alb.	-	ʒi.
Aqua dist.	- -	ʒi.

to be used hot and frequently.

The fomentation gives almost immediate relief and the sulph. calcis hastens formation. This treatment dispenses with use of the lancet and avoid scars or cicatrix.

Yours Truly,

D. GENESE, D.D.S.

Society Reports.

BALTIMORE ACADEMY OF MEDICINE.

STATED MEETING HELD MARCH 2, 1886.

Dr. Samuel Theobald read a paper on a case of

CONVERGENT SQUINT ASSOCIATED WITH A HIGH DEGREE OF MYOPIA, RESTORATION OF BINOCULAR VISION.*

Dr. J. J. Chisolm had operated two years ago on a man æt. 19 years, who had marked squint and myopia to a high degree. He got binocular vision by correcting the squint in one eye.

He related a case of a woman who had such an extreme convergent squint that it was impossible for her to straighten either eye. He has operated upon her three times with varying degrees of benefit.

Dr. Theobald thought it singular that neither eye could be straightened.

Dr. Chisolm said that it was queer but the fact was that *neither* eye could be straightened. He attributed the extreme squint to extensive choroidal troubles. Fourteen years ago he operated on a boy for internal strabismus, one year ago he saw him again and gave a history of good vision for thirteen years, but when the last year was reached a divergent squint developed. Vision in each eye was good, but they could not be used together.

Both eyes were then operated upon at intervals of three months. The tendons of the external recti were cut and the internal recti were advanced. This corrected the divergence, but caused one eye to look upward while the other looked downward. In order to correct this defect it became necessary to cut the upper rectus of one and the lower rectus of the other, when the desired effect was obtained.

Dr. H. P. C. Wilson read a paper on

CIRCUMSCRIBED PERITONEAL DROPSY SIMULATING OVARIAN TUMOR.†

DISCUSSION.

Dr. S. C. Chew asked if any symptoms had existed which might have pointed to existing peritonitis.

Dr. Wilson said absolutely none. He could hardly conceive of a woman with such an extensive peritoneal inflammation and no symptoms pointing to it.

Dr. B. B. Browne, was the fluid in a sac?

Dr. Wilson, no—it was in an apartment shut off from the rest of the abdominal cavity by a mass of adherent intestines.

Dr. B. B. Browne had seen a case in which the fluid was entirely encysted and shut off from the peritoneal cavity. He had seen a colored woman who was supposed to have an ovarian tumor—beside this there was a distinct enlargement in the left side, the tumor on the right side proved to be a cyst filled with fluid, one and one half gallons of which were drawn off, when the tumor in the left side disappeared—it proved itself to have been the uterus pushed from its normal position over to the left by the fluid accumulation on the right.

Dr. Allan P. Smith asked Dr. Wilson if there was any evidence of reaccumulation of fluid in his case.

Dr. Wilson, none. He also said in answer to Dr. Chisolm, that the adhesions were friable and that is what he could not understand, they must have been of recent formation, and hence an acute process; but why the absence of symptoms?

Dr. A. P. Smith said a woman in such a condition was always liable to sustain a strangulation of the intestines.

Dr. S. C. Chew related a case he had seen of a young woman 22 years of age, who complained of pain in the left side with gradually increasing tumor. Palpation revealed a hard firm mass continuous with the spleen. No positive conclusion could be arrived at by the analytical methods of diagnosis. Malarial spleen was suggested, but she never had had a chill.

The absence of albumen and casts in

*Will be published in the *Archives of Ophthalmology.*

†See page 417.

the urine excluded amyloid degeneration of the viscera. As the proportion of leucocytes in the blood was shown by microscopic examination to be but little increased, leucocythemic spleen was in turn abandoned.

The autopsy revealed a large mass lying in the right side of the abdomen, the body of which was kidney. It was adherent to pancreas, omentum and liver. Calibre of ureter on this side completely obliterated.

He thought diagnosis lay between medullary carcinoma and sarcoma. The left kidney seemed to have taken on a vicarious function.

A BRAIN SHOWING EVIDENCE OF AN OLD HEMORRHAGE.

Dr. F. T. Miles spoke of a man whom he had seen last July. At that time the patient had left hemiplegia to a limited degree, was slightly aphasic and suffered from mania—the latter condition becoming so intense that the man became very violent and it became necessary to confine him to an asylum—By the following fall he had almost recovered his mental equilibrium, but was still quite nervous. It was evident however that some slight mental impairment still existed, as was shown by his taking half pint of some decoction that he termed "cholagogue." From this dose he had violent vomiting attacks at intervals. During one of these intervals he suddenly died.

At the autopsy death was found to have occurred from a rupture of the aorta. Excepting a very slight thinning of this vessel no other pathological change could be found.

The brain was interesting—on the left side there there was evidence of an old hemorrhage that had given rise to the hemiplegia from which he had almost recovered. On the right side the lenticular ganglion was entirely destroyed, thus completely shelling out the island of Reil.

He thought the condition on the left side illustrated very nicely the state of affairs during the process of recovery from a hemiplegia, for the hemorrhage had been almost entirely absorbed.

The heart presented no evidence of any acute or chronic ulcerative process. Dr. Miles said that he had often been impressed by the enormous size of the aorta in old negroes in the south, the condition existing entirely indedendent of any heart trouble.

A CASE OF ASTIGMATISM.

Dr. J. J. Chisolm reported a case of a young lady, æt. 24 years, who suffered from painful eyes for eight months as a sequel to some one of the fevers; he could not say the nature of the illness. Her distant vision was good; she read fine print at the usual range, but the use of her eyes caused intense headache, consequently she had used them but little for some months.

Two specialists whom she consulted, diagnosed the condition as that of choked disk consequent upon cerebral tumor, and gave as their opinion that the case would probably terminate fatally.

When seen by Dr. Chisolm, ophthalmoscopic examination showed the disk to have a blurred outline, but he could see no reason for attributing it to the presence of a cerebral tumor. She was found to be astigmatic. This was corrected with glasses and she now, after three weeks, reads perfectly and painlessly.

He could not understand why two competent men should have diagnosed cerebral tumor for choked disk and nothing else.

He finds a very slight astigmatism may, if not corrected by glasses, give rise to great pain.

Dr. Samuel Theobald has seen the disk in an astigmatic eye so congested from strain, that it was difficult to distinguish it from the surrounding choroid. He finds that there is greater trouble in astigmatic eyes when the shorter radius approaches the horizontal, than when the reverse is the case, the reverse being the rule.

The Philadelphia Polyclinic and College for Graduates in Medicine has recently established a hospital at the College building, cor. of Lombard and Broad Streets, Philadelphia.

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BALTIMORE, MARCH 27, 1886.

Editorial.

THE IMPORTANCE OF AN EXPLORATION OF THE UTERINE CAVITY IN CASES OF SEVERE, PERSISTENT OR RECURRENT UTERINE HÆMORRHAGE.—In a recent discussion before the Baltimore Medical Association (see MD. MED. JL., March 13th, 1886,) the importance of exploring the uterine cavity, and of removing retained pieces of placenta after child-birth or abortion, was insisted upon as a necessary procedure. Attention was called to the fact that the risk involved in the curetting of the uterine cavity was less than the one to which the patient was exposed from the retained masses of placental tissue. It seems to us the fact asserted in this proposition is worthy of a more emphatic statement. It is well-known that authorities disagree in regard to the importance of this procedure. It is quite easy to cite an array of opposing arguments which would seem to confuse an intelligent judgment seeking a true solution of a question, which, in our opinion, admits of but one correct interpretation.

The fact that eminent controversialists find ground for argument upon theoretical points of practice should not deter one from a practical and matter-of-fact rule of action. In theory we may find comfort for having fallen into a given line of treatment, but in practice we must be guided by facts capable of demonstration by their results. What then are the results of these two methods of dealing with the retained products of child-birth or abortion? Upon the one hand we have the risks of septicæmia, sub-involution and subsequent uterine hæmorrhage, and, upon the other, the comparatively safe and harmless procedure of exploration and removal. Having adopted the former method of dealing with these retained products, it does not follow that the latter method of procedure may not be required at a subsequent period, but this rule does not work conversely. The products once removed the source of danger, or of annoyance, from septicæmia, arrested involution, or hæmorrhage is no longer a factor in the treatment of the case.

It seems to us that for every single argument which can be advanced in favor of the expectant method of dealing with retained secundines, ten facts can be adduced in support of the procedure of exploration and removal. Passing from the present condition to the remote results which may supervene from retained placental masses, we are likely to be brought face to face with some form of uterine hæmorrhage which will demand earnest professional attention. It is true, we believe, that menorrhagia and metrorrhagia are more frequently due to the retained products of child-birth, or of abortion, than to all other known causes, unless we accept sub-mucous fibroids or polypi. When these hæmorrhages exist the tendency is to treat them as special diseases rather than as symptoms of the conditions named. There can be only one safe method of dealing with uterine hæmorrhage under these circumstances. A correct diagnosis of the underlying cause is the only road to successful treatment.

Having eliminated the many possible causes which may induce uterine hæmorrhage independent of any condition of the uterus itself, a local investigation of this organ is demanded. No patient should be allowed to continue bleeding indefinitely without an attempt to ascertain the cause of the hæmorrhage and an effort to remove the same. In many of these cases it is a waste of time and effort to employ drugs. Nothing short

of an exploration of the uterine cavity, and a removal of the retained portions of placental tissue will effect a cure.

With the means of dilating the cervical canal, which are within the reach of every surgeon, the divulsion of the uterus is no longer as grave a surgical procedure as a few years back. The facility of exploration has been vastly simplified, and the operation of curetting is greatly facilitated thereby. It cannot, however, be claimed that divulsion or curetting are free from grave risks. They may be said to belong to the class of capital operations, and should, therefore, be executed under strict antiseptic precautions, and with those minute attentions to details which belong to all major surgical procedures. Anæsthesia, rest in the recumbent posture, attention to diet, hygiene, etc., are necessary accompaniments and should never be omitted.

By the substitution of an exact method of diagnosis and treatment of uterine hæmorrhage for the method of uncertain causation and of indefinite therapeutics, the gynecologist of to-day is prepared to secure results which were not possible a few years ago. By promptly removing causes, symptoms, as well as their underlying diseases, are liberally discounted in advance, and much time and suffering, incident to the expectant method of treatment, are consequently avoided.

The Treatment of Diphtheria by the Galvano-Cautery.—There is perhaps no disease which is brought under professional attention that has called into requisition a larger list of therapeutic agents for its treatment than diphtheria. There is scarcely a drug worthy of mention which has not been at some time suggested or employed in the management of this grave malady; whilst of the specifics which have been extolled by earnest advocates, their name is legion. Mercury, quinine, iron, potash, *et id genus omne* have stood the trial of professional test in diphtheria and have called forth sincere praise from numerous directions. If a true specific for diphtheria exists, it is safe to say, its name is not yet known.

Each year some new method of combatting diphtheria is either suggested or some old method is revived and brought into practice. The wheel of fortune is being constantly turned and something is sure to fall to the credit of the diphtheritic process. Some years ago the cauterization treatment of diphtheria was suggested, but, like many other measures proposed for this disease, it soon fell into disuse.

We are now able to announce a revival of this practice in the use of the galvano-cautery. The credit for this suggestion belongs to Dr. Bloebaum, of Koblenz. Dr. Bloebaum's experiments have been published in various German journals, but we are indebted to the *Therapeutic Gazette* (March 15th, 1886,) for his methods of treatment. Dr. Bloebaum began his investigations by using the galvano-cautery in various septic, and especially diphtheritic processes, which were articially produced for the purpose. He noted how young diphtheritic pigeons, which were already cyanotic and unable to feed, after a single cauterization could on the following morning fly about and eat freely. He observed that no inflammatory swelling of the cauterized parts and its surroundings could be detected; on the contrary, they looked healthier than before and in a few days healed altogether. After sufficient and satisfactory observation on animals, the galvano-cauterization was employed in the treatment of diphtheria in man. The results were incredibly prompt and satisfactory. Besides gargles of ice-water, no other medicinal interference of any kind was admitted. The procedure, Dr. Bloebaum asserts, is wholly painless and healthy granulations were in every instance noted to spring up from the cauterized part.

The *Therapeutic Gazette*, reviewing Dr. Bloebaum's apparently reliable statements, formulates the following conclusions: "1. The galvano-cauterization of the diphtheritic membrane produces no pain, or only minimal one. 2. The thoroughly cauterized part is rendered absolutely sterile, and forbids the development of microbic life. 3. Fever disappears soon after the cauterization.

4. No inflammatory secondary effects set in. 5. Every physician is able to execute the cauterization, even without an assistant. 6. No constitutional medicinal treatment is needed in addition to the cauterization. 7. Though statistics of diphtheria cases thus treated of course are yet very limited, the thousands of ulcers of the cornea treated and cured in the same manner allow of very favorable prospects regarding the treatment of diphtheria with the galvanic-cautery."

We quite agree with the *Gazette* in the statement that cauterization in its present perfect form insures an ideal *antiseptic* effect and must prove fatal to the pathogenic agent of diphtheria, and that the soil treated by fire can give no nourishment whatever to such microbes as perhaps have escaped death by fire. That the sure and rapid destruction of septic agents is effected by the cautery it would be difficult to deny, and then taking into consideration the harmlessness of its application, this method of treatment seems to us worthy of confidence and trial.

The Use of Atropine to Prevent Shock after Operations.—Every surgeon would willingly discount the shock, which is a frequent accompaniment of grave surgical operations, were the means of doing so always at his command. The use of atropine for this purpose has been extolled by Dr. L. A. Stimson, of New York, in a recent discussion before the New York Surgical Society (*Medical News*, March 20, 1886, p. 329). For upwards of three years Dr. Stimson has been in the habit, in cases which were to undergo grave operations, of employing a small quantity of atropine hypodermically just before beginning the operation. He was led to this use of atropine by knowledge of the fact established by physiologists that it would prevent the inbibitory action upon the heart of efferent pneumogastric currents excited by irritation of important sensory nerves. He has tried it in a number of cases in amounts varying from $\frac{1}{64}$ to $\frac{1}{96}$ of a grain and he believes it has directly contributed to the success of the operations.

Dr. Stimson found it difficult to speak with precision on such a point, because of the lack of positive evidence, but he could say that patients thus treated had left the table with a better pulse and less collapse or shock, than those who had not been protected by the use of atropine.

Miscellany.

Phenic Acid in Intermittent Fever.—Dr. Narich's communication to the *Progrès Médical* of January 30, 1886, on the curative power of phenic acid cannot fail but invite universal attention.

Though no physician would venture to question the miraculous and truly specific influence which the Peruvian bark and its numerous alkaloids exert over the malarial intoxication, it is nevertheless an incontestable fact that occasionally patients are encountered who declare that quinine or any other form of cinchonization has utterly failed to relieve them. And if the physician then, remembering the instructions of his clinical teachers, or those of his textbooks, exhibits arsenic, and finds that even this drug does not check the dreaded paroxysms, and that his patient rapidly approaches the limits of exhaustion and nutritive failure, he is truly in no enviable dilemma. Such a patient presented herself for treatment to Dr. Narich, of Smyrna, in Asia Minor, and asked to be treated by a new remedy, as the standard treatment did not benefit her. The patient, who was an intelligent lady of about 35 years, had suffered for the last year of quotidian marsh fever, and had consulted both the Arabian and European physicians of her country. Quinine and bromides were prescribed together, and given for seven days, morning and night, without producing any results. Arsenic was tried, and failed likewise.* Having once heard of the advantages of phenic acid in refractory cases of malaria, Dr. Narich re-

*This reminds us that Dr. M. E. Hensler, of West Franklin, Indiana, reported some years ago a number of refractory cases of marsh fever cured by the combination of arsenic and quinine. He gave 15 grs. of quinine morning and evening, and at the same time 3 tablespoonfuls of a solution of ½ dr. of Fowler's solution in 3 fluidounces of water.

solved to try this drug hypodermically. He dissolved seven grains of the crystals in two fluidounces of water, and injected a small quantity in the right arm. There appeared redness, with elevation, and a somewhat erysipelatous appearance round the point of injection, but disappeared soon after. A second injection was followed by a rather painful induration which lasted four days. His mode of injection was as follows: On the first day he injected one syringeful. On the four succeeding days six syringes daily,—three in the morning and three at night. All in all, thirty-three injections were made. On the fifth day the patient complained of malaise, which increased on the following day, and forced the physician to discontinue the injections on the seventh day. Since the twentieth injection, however, up to date of the publication, for an interval of nine months, the patient has had no more paroxysms.

Although the successful employment in a single case of a certain drug does not suffice to establish its virtues, the phenic acid injections should be borne in mind by those practitioners who have to deal with some very refractory cases of malaria, in which the usual medication has failed.—*Ther. Gaz.*

Medical Items.

The Woman's Medical College of Pennsylvania recently graduated a class of thirty-three, and celebrated its 34th annual commencement.

The Cartwright Lectures will be delivered this year by Professor William Osler, of Philadelphia, on "Certain Problems in the Physiology of the Blood."

Honors continue to crowd upon M. Pastuer. The king of Italy has recently decorated him, and the Académie de Médecine has voted the sum of $2,000 for the projected Pasteur Institute.

It is reported that Dr. W. H. Pancoast has resigned the chair of Anatomy in Jefferson Medical College, Philadelphia, after his connection with this school for a period of 30 years. The reason assigned is that his private practice absorbs all of his time.

The furneral services of the late Dr. Austin Flint were held at Christ Church, New York City, on March 16th. The church was crowded with the friends, colleagues and pupils of the deceased. The *Record* says, "hardly a prominent medical man in the city was absent, and the gathering was a remarkable and spontaneous tribute to the memory of the departed."

The fifty-third annual meeting of the Medical Society of the State of Tennessee, will be held in Memphis, commencing Tuesday, April 6th, 1886. It is expected that this meeting will prove one of the most interesting and profitable in its history. Railroad rates have been reduced for the benefit of delegates and members attending the meeting.

Recent news from Vienna states that Dr. Robert L. Randolph, class of 1885, University of Maryland, has been appointed one of the thirty assistants at the "Poly-clinic." He is the only English speaking (by nationality) one of the thirty. Dr. Randolph is the son of the Rt. Rev. A. M. Randoph, assistant Bishop of Virginia.

The twenty-fifth annaul commencement of Bellevue Hospital Medical College was held on March 15th. The degree of M.D. was conferred on 139 graduates. A noticeable feature of the occasion was an eulogy upon the late Professor Austin Flint, Sr., pronounced by Professor John C. Dalton, of the College of Physicians and Surgeons.

Titles for periodicals are becoming scarce: Dr. Sara E. Post, of New York, has commenced the publication of a new journal devoted to the interest of nursing, to which she gives the name of "The Nightingale." This is, however, not quite as appropriate as the title given to a new journal about to be published in Chambersburg, Pa. This publication will be devoted to suicide, homicide, funerals, etc. It will be called "Death".

The *Medical Record* says: "Two prominent physicians of Chicago have recently had civil suits brought against them for alleged damages in sums of $5,000 and $6,500, the real animus being, so far as known, the fact that the doctors had sued for the collection of their bills. Inasmuch as it only cost six dollars to commence suit against a physician, with no further liability to the plaintiff—whatever may be the result—this appears to be a cheap sort of revenge."

Changes in the staff at the University of Maryland. Dr. Randolph Winslow, who has been Demonstrator of Anatomy for the past six years, retires from the position and will be succeeded by Dr. Herbert Harlan, formerly Assistant Demonstrator. Dr. Winslow will continue his connection with the School as Clinical Lecturer on Surgery and will have a Surgical service at Bayview Hospital. Dr. Ridgely B. Warfield, Assistant Resident Physician for the past year at the University Hospital, has been elected Resident Physician for the University at Bayview Hospital. Dr. C. E. Sadtler Dispensary Physician at the University Hospital and Dr. F. J. Flannery Assistant, have been re-elected.

Original Articles.

OVARIOTOMY DURING ACUTE OR CHRONIC PERITONITIS.*

BY P. F. MUNDÉ, M.D., OF NEW YORK.

It has been my misfortune in my experience with the operation of laparotomy for abdominal tumors to meet with the most complicated and unfavorable cases. Thus of sixteen double ovariotomies, there were four intraligamentous cysts, three of which contained pus and were not removable except by piecemeal; in two cases the walls of the cyst were practically rotten and so friable as to break down under the slightest manipulation; in one case there was a suppurating dermoid cyst with extensive adhesions to the bladder and pelvic wall; and in two cases previous rupture of the cyst with the production of diffused chronic peritonitis had taken place. Adding to this latter category three cases of single ovariotomy during chronic peritonitis, in two of which the peritonitis was due to rupture of the cyst, and in the other to aspiration, and I have had five cases of ovariotomy performed during general peritonitis, one acute and four chronic. Certainly this array of complications does not forecast a high rate of recovery; and in reality it stands at 50 per cent. of double ovariotomies. But I have the satisfaction of knowing that one patient recovered after operation during chronic peritonitis; one after removal of a suppurating dermoid cyst with lesion of the bladder and catgut suture; one after removal of a multilocular cyst weighing 50 lbs., all double ovariotomies, and one after partial excision of a huge cyst of the broad ligament, containing 48 pints.

Of my single ovariotomies nearly all recovered. But it is not my object to report here my results in ovariotomy (I must wait until the number of my cases has greatly increased before it is worth while to do this), but to relate very briefly the cases in which I have been so unfortunate as to have presented to me conditions for which I deemed it my duty to operate, and still in which the chances for recovery were next to nothing. I think that from a consideration of these cases some practical deductions for future guidance may be gathered. At all events I hope to elicit valuable hints from the discussion. I feel it but just to myself to state that in operating upon these, often really desperate cases, I have been actuated by the rule very properly, as I think, laid down for his own guidance by Dr. Goodell, never to refuse to operate in any case which, in his opinion, offered the slightest chance for the recovery of the patient. And with him, I have thereby, no doubt, greatly injured my statistics of recovery. But as we usually learn quite as much, if not more, from our failures than we do from our successes, I do not hesitate to report the five cases of ovariotomy during peritonitis, only one of which recovered, feeling that I have nothing to reproach myself for, either in venturing to operate or in the after treatment. As to the justifiability of immediate removal of an ovarian cyst during peritonitis, acute or chronic, as soon as the existence of the latter condition is discovered, there can probably be no question, since the brilliant results of Keith, Freund, Veit, Tait and many others in operations of this kind, some of the apparently most desperate cases have recovered after removal of the ovarian cyst and drainage.

The peritonitis may be due to two causes: 1. The inflammation and mortification of the cyst; and 2. Its rupture and the escape of its contents into the peritoneal cavity; and it is on these two points the diagnosis of the cause and presence of the peritonitis, and the treatment of the cyst contents effused into the peritoneal cavity, that I desire to dwell more particularly. 1. The cause of the peritonitis may be either accidental rupture of the cyst, by violence or spontaneously, the cyst walls having become inflamed or friable by torsion of the pedicle, outside violence, or without known cause; or, a not unfrequent occurrence, aspiration or tapping of the cyst may have excited inflammation of the

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sac or peritonitis. The diagnosis of acute peritonitis in such cases is based on the general principles on which that condition is recognized. Subacute and chronic inflammation of the peritoneum, however, are more obscure, and can be suspected or clearly discovered chiefly by a rise of temperature, with morning and evening exacerbations, a dry furred tongue, quick small pulse, general depression, in fact symptoms similar to those characteristic of typhoid fever. There is some tenderness over the abdomen, which is of course distended if an ovarian cyst is present, but the distention is not so prominent and ovoid as is usually found with that disease. The occurrence of rupture of an ovarian cyst may be surmised from the statement of the patient that at some period more or less remote a sudden pain was experienced in the abdomen, as though something had given way, and that thenceforth she had diffused abdominal pain, fever and general prostration; further, from the appearance of the abdomen, which is flat, while distended, simulating ascites, with tympanitic resonance over the prominent portions and dullness in the flank, which relations do not change, or but slightly, on the patient assuming the lateral decubitus. It it were ascites, the area of dullness and resonance would change on altering the position, but the thick ovarian fluid does not shift so easily as the watery ascitic discharge. Besides there is a boggy, doughy feel of the whole abdomen, different from either ascites or ovarian cyst, and similar to œdema of the abdominal parietes. The umbilicus, which is usually somewhat prominent in ovarian tumors and ascites, remains flat if thick ovarian fluid is scattered among the intestines. A wave of fluctuation is usually not perceptible, or very indistinct, after rupture of an ovarian cyst, unless the fluid is very thin. *Per vaginam* only a very diffuse, indistinct sense of resistance is felt in the vaginal vault. On bimanual examinations no distinct cysts with firm elastic walls are felt, but the experienced diagnostician will detect a flaccid, yielding, boggy mass in the abdomen which varies in dimensions in accordance with the time allowed the cyst to refill since the last rupture. Only practised touch will recognize this peculiar sensation, and appreciate its relation to the general condition of the patient. 2. The *treatment* of an ovarian cyst complicated by chronic peritonitis, be the latter due to aspiration or to rupture of the cyst, invariably is, laparotomy, removal of the cyst and cleansing of the peritoneal cavity so far as possible, followed by drainage. There can be no doubt as to the justifiability of this practice; too many operators of the highest eminence have adopted it, and its success as a whole has warranted their action. But as to the treatment of the contents of the cyst which were effused into the heretofore presumably healthy peritoneal cavity, there exists some difference of opinion. While *eo ipso* the only correct treatment would seem to be the immediate careful removal of *all* the noxious contents of the ovarian cyst from the peritoneal cavity by sponging and irrigation, experience seems to show that drainage will, in course of time entirely and safely remove the ovarian fluid (which is often colloid, that is thick and glutinous), and that no harm accrues to the system by allowing this usually irritating matter to remain in prolonged contact with the peritoneum. In explanation of this apparent immunity, it should be noted that the peritoneum doubtless has, by chronic inflammation become proof against fresh irritation.

My experience warrants me in stating the belief that it is safer to leave the gradual elimination of the effused ovarian fluid (be it thick or thin) to the medium of the drainage tube, than to attempt to remove it manually (if it be stringy and colloid) by prolonged careful sponging, or by copious antiseptic irrigation of the abdominal cavity. I cannot but think that the traumatic irritation of the first procedure, and the shock following the irrigation of as large a surface as the intestino-peritoneal area by an antiseptic lotion, (particularly bichloride), are more injurious and hazardous than to allow free voluntary drainage through a tube. I am impelled to this conclusion by the result of a case operated on by

Lusk during the first year (reported to me by Polk, who was present at my fourth operation of this kind, and who concurred in the treatment), and another reported by Max Runge (*St. Petersburger Med. Wochschrift*, Jan. 2, 1886), in both of which rupture of the cyst took place, an enormous quantity of thick gelatinous matter was found in the peritoneal cavity which was removed gently so far as possible, the cavity was then drained and recovery took place. In Runge's case colloid matter was discharged from the drainage tube as late as the fortieth day after operation. That the danger of fresh septic infection, of relighting the subacute peritonitis, and above all of seeing the patient die from shock, stare the operator in the face in such cases, can unfortunately not be denied. It is a question simply of leaving the patient to a certain and lingering death, or of giving her the chance of recovery by an operation, the results of which have been often most favorable. My own individual results should be no criterion, since my cases have been exceptionally difficult and unfortunate.

After these preliminary remarks, which have attained a length quite unintended, I will give a brief report of my five cases of ovariotomy during peritonitis:

Case I.—Age 33, single. November, 1875, apparently unilocular cyst; abdomen exceedingly tense. Operation refused. In order to gain time and to relieve tension aspiration, with fine needle, under antiseptic precautions. Removal of the chocolate colored fluid. About a week later high temperature, peritonitis. Ovariotomy, November 14th; patient with pulse 120, temperature 99.5, exceedingly prostrated. Cyst entirely removed; peritoneum studded with flocculent lymphatic adhesions and deposits. Drainage. Death on sixth day, from septic pyemia, the right paroted gland showing probably metastatic enlargement and suppuration. Earlier operation might have saved this case.

Case II.—Mrs. F., 44 years, multipara, large, apparently solid tumor. Operated on March 10th, 1881, colloid matter escaped on opening peritoneal cavity. A large multilocular tumor adherent to bladder and intestines. Fully fifty ligatures were applied; thorough syringing. No drainage. Recovery without a bad symptom. Weight of tumor 35 lbs.

Case III.—Mrs. S., 38 years, single, was seen by me in September, 1883; lived in a farm house in New Hampshire, 17 miles from Hanover. Evidently in a septic condition. Double ovarian tumors. Advised removal as last desperate chance. Accepted. Day appointed for operation about one week later. Drove out with assistants and found patient greatly weakened by vaginal hæmorrhage the night before. I discountenanced the operation, but she insisted upon it. Pulse 130, temperature 102°. On opening the abdominal cavity gush of colloid and purulent matter; general chronic peritonitis. Right tumor largely adherent; left intraligamentous, rotten and removable only by piecemeal. Death of patient while inserting abdominal sutures.

In this case I should never have consented to operate but for the urgent request of the patient and the fact that I had come so long a distance to do the operation. Had the second tumor not been intraligamentous and as difficult of removal, I firmly believe that I could have at least removed the patient from the table alive.

Case IV.—This was the most interesting and instructive of all my cases. The patient was a nullipara, who in August, 1883, had a fall on the abdomen, and then noticed an abdominal enlargement, with severe pain, both of which had increased since. The abdomen was found, in March, 1884, when I first saw her, to be flat, with projecting sides, dull on percussion, indistinct fluctuation, which remained unaltered on changing the position of the patient. On the right side a loose, flaccid mass could be felt. Aspiration was performed but nothing obtained. On the left side deep in the pelvis was found a tumor of the size of a cocoanut, with tense walls. Diagnosis of rupture of ovarian cyst of right side (probably colloid on account of absence of fluid by

aspiration) and of intraligamentous cyst of left side was made, and early operation advised. But as patient still felt pretty well, she decided to wait. Three weeks later she returned very much worse and desired immediate operation. Temperature 103°. On opening the peritoneal cavity, colloid, stringy matter escaped in enormous quantity, and it required careful manual efforts to remove even a semblance of all the effusion which reached from Douglas' pouch to the diaphragm. It seemed to me and to those who assisted me, imperative to remove as much of this supposed toxic material as possible, and I finally decided to irrigate the abdominal cavity with a 1 to 2000 solution corrosive-sublimate, with the patient on the side. The colloid matter came from a cyst of the right ovary, as diagnosed three weeks before the left cyst was enucleated, and proved to be full of fœtid pus. The colloid matter removed weighed 13 lbs. The highly prostrated patient died of shock 22 hours after operation. I feel fairly confident that if I had allowed the colloid matter to find its way out of the peritoneal cavity gradually through a drainage tube, under proper antisepsis, the patient would have stood a far better chance of recovery, as did those of Lusk and Runge.

Case V.—Mrs. K., 47 years, one child 28 years ago, was brought to me on the 1st of this month for an abdominal swelling and great prostration dating only five weeks back. I found a well-nourished but cachectic looking woman whose abdomen was but little distended, but in whom I could detect, on careful bi-manual examination, a flaccid tumor the size of an adult head, on the right side. Percussion resonant except on the right side. Considerable diffuse abdominal pain. Diagnosis, apparently growing ovarian cyst, indicating speedy operation on account of cachexia. On March 3d, while stooping, sudden abdominal pain and collapse; temperature 102.2°; pulse small and thready. Operation having already been fixed for March 14th, was not postponed; on the contrary, the indications for speedy operation seemed increased by the recent urgent symptoms. Feel and appearance of abdomen changed since last examination; tumor less distinct and in centre. On opening the abdomen gush of evidently ovarian fluid in large quantity; peritoneum highly congested and covered with recent lymph deposits, certainly much older than eighteen hours (date of pain etc., day before). Tumor proved to be of left ovary, was very friable, and certain loculi contained pus which escaped into the peritoneal cavity while the mass was being removed; small pedicle. Thorough sponging but no irrigation of peritoneal cavity. No shock. Drainage. Symptoms of peritonitis on second day, temperature 102.8° (above which point it never rose). Obstinate vomiting in spite of absolute discontinuance of nourishment or medication per os, and death yesterday morning, that is on the fourth day. But very little bloody serum escaped through the drainage tube.

I confess that when I decided to speak on this subject before this Society, I hoped and believed that I had every reason to expect this patient to recover. But although sorely disappointed I feel that I have not been to blame and that but for the uncontrollable vomiting (which of course was reflex from the peritonitis) the patient might have recovered.

I have not come before this learned Society to offer advice, but merely to bring before it my experience in this particular class of ovariotomies, with the hope of learning some points from the gentlemen present which may aid me in improving my record of recoveries in cases complicated by acute or chronic peritonitis.

Russia has 33,400 physicians, of whom 380 are females. There are 2,100 persons licensed to practice veterinary surgery. 500 are enrolled as dentists and "oculists."—*Boston Med. and Surg. Jour.*

Society Reports.

BALTIMORE GYNÆCOLOGICAL AND OBSETRICAL SOCIETY.

REGULAR MEETING HELD MARCH 9, 1886.

First Vice-President, H. P. C. Wilson, M.D., in the chair. Wm. E. Moseley, M.D., Secretary.

Dr. P. F. Mundé, of New York read the following paper:

OVARIOTOMY DURING ACUTE OR CHRONIC PERITONITIS.*

DISCUSSION.

Dr. T. A. Ashby remarked that Dr. Mundé had called attention to grave troubles following the rupture of cysts into the abdominal cavity. He would like to ask the doctor if he had had any experience with cases in which the cyst contents had been poured into the peritoneal cavity as the result of accidental rupture of the cyst wall and still no unfavorable result had followed. Dr. Ashby thought this was an exceptional way in which nature dealt with certain cases, the cyst wall being accidently ruptured by some violence and the cyst contents effused into the peritoneal cavity. Being of an unirritating character it was absorbed and eliminated. He referred to a case reported by Dr. I. E. Atkinson, of this city (Maryland Medical Journal, vol iv. p. 229). This case was one of a cyst within the abdomen, diagnosed as *probably* ovarian, *possibly* of the broad ligament. The tumor had reached the size of a pregnant uterus at the seventh month, when it ruptured and its contents were poured into the abdominal cavity. The growth had not returned at the time the case was reported.

Dr. B. B. Browne said that after the rupture of the cyst in Dr. Atkinson's case, there was discharged a large amount of fluid from the bladder and the question arose whether from chronic peritonitis the cyst had become adherant to the wall of the bladder and ruptured directly into that viscus, or the contents had escaped into the abdominal cavity and had been taken up and passed off by the kidneys. The patient made an uninterrupted recovery.

Dr. W. P. Chunn thought Dr. Mundé deserved great credit for operating upon so unpromising a set of cases and also for so fully reporting his results. A correct prognosis could only be arrived at after the collection of a much larger number of statistics than we now possessed. It was in just such cases as those reported by Dr. M., that abdominal surgery had made some of its greatest advances. He felt comforted by the doctor's remark that it was unneccessary to sponge every particle of effused fluid out of the abdominal cavity as the drainage tube could be depended upon for its ultimate removal. He referred to a case upon which he operated and in which some of the cyst contents, a thick sticky fluid, even after careful sponging, had to be left in the abdominal cavity. A drainage tube was used with a good result. He thought Dr. Mundé's remarks upon the diagnostic signs were of special value.

Dr. H. P. C. Wilson thought the position taken by Dr. Mundé was the correct one, that if there was the least chance of saving a patient's life we were in duty bound to give her that chance without considering what our record might be in a given number of operations. He did not consider the cutting into an abdominal cavity involved in general peritonitis, as desperate a procedure as had been supposed. As bearing upon the subject he related the following case. A woman was sent to him, by a skillful physician, for the removal of a cystic tumor of the ovary. The patient was about 38 years old, the mother of seven children, the youngest 2 years old. She reported that she had never had a day's sickness in her life and in this was confirmed by her physician. There was no abdominal tenderness. A careful examination by himself and Dr. R. T. Wilson, left no doubt in their minds that the case was one of simple ovarian cyst. Under antiseptic precau-

*See page 437.

tions, including the spray, Dr. R. T. Wilson opened the abdomen, when about one and a half gallons of greenish yellow fluid escaped. The case proved to be one of general peritonitis, with a circumscribed peritoneal dropsy, the fluid being confined to the lower front part of the abdomen, and the cavity was formed by agglutination of the intestines behind with adhesions of the omentum and layers of lymph. The patient made a good recovery. He would not hesitate to cut for an ovarian tumor because of the presence of acute or chronic peritonitis. He agreed with Dr. M. that the abdominal cavity should not be sponged out more than absolutely neccessary and very gently.

With regard to washing out the abdominal cavity with antiseptics, he would say that, in a case in which he made an exploratory incision with the view of removing a kidney, he found a fibro-sarcoma of such dimensions and adhesions that the operation was abandoned. It was necessary to use drainage, and two soft rubber tubes were placed by the side of the tumor and the incision closed. Bi-chloride solution (1 to 2000) was injected through one tube, and allowed to run out through the other, twice daily for several days, until the incision being nearly healed and the water coming away clear, the drainage tubes were removed and the patient was considered out of dangor. On the eleventh day symptoms of tetanus set in and the patient died on the seventeeth day. Dr. Wilson said he thought the antiseptic had nothing to do with the patient's death and that had it not been used she would have died of septicæmia.

In a case which was sent to him as a simple ovarian cyst, and which he considered such, the patient, shortly before the time appointed for operation, upon trying to rise from her bed felt a sharp pain followed by collapse. Subsequent examination showed that the tumor had disappeared. The patient made a good recovery and has had no return of her trouble.

Dr. W. E. Moseley would consider it wiser in all cases, where the cyst contents found their way into the peritoneal cavity, to remove as much as practicable of the fluid. He would not favor violent sponging, as much harm might be done in that way, but he thought a great deal could be accomplished by irrigating the abdominal cavity. He had seen this resorted to by Dr. T. A. Emmet and did not think any outward result could be attributed to its influence in any case he had had the opportunity to study. He would not be willing to use a 1 to 2000 solution bi-chloride of mercury in this free manner within the peritoneal cavity as, however carefully it was drained out, the large amount of surface would retain a considerable amount of the fluid and he would fear poisonous effects. He thought that water, freshly boiled in covered vessels and used directly from them and at the body temperature would be thoroughly aseptic and would be as effective in every way and devoid of the irritating properties of the bi-chloride solution. He did not feel that his experience warranted him in speaking with any great degree of positiveness, but his predilection in cases of colloid or purulent material would be in favor of careful irrigation as described with the use of the drainage tube, if necessary, as an adjunct.

Dr. P. F. Mundé, in closing the discussion, said he was satisfied that in many cases cysts ruptured into the abdominal cavity, and their contents were absorbed without any peritonitis resulting. In one case, reported by Dr. T. G. Thomas, rupture had taken place several times, temporarily delaying the operation. In one of Dr. M.'s own cases, a small tumor, the cyst had ruptured and had never filled again. He had also ruptured a small cyst intentionally without bad results. Dr. Noeggerath had reported that he had ruptured small ovarian cyst in several instances with good results, as had also Dr. Polk, of New York.

As to just what character of fluid was irritating to the peritoneal surface we had no positive knowledge, but probably the most irritating was the thick, tenaceous, so called colloid material. He did not wish to carry the impression that

he disapproved of carefully sponging the abdominal cavity except in cases where there was present a thick colloid material which would require an excessive amount of manipulation and even a decided scraping for its removal.

He thought Dr. Moseley's remarks were very pertinent. The case in which he had irrigated the abdominal cavity with solution of bi-chloride mercury 1 to 2000 was operated upon some three years ago, when our knowledge of the deleterious effects of this antiseptic was much less perfect than at present. Of late he has always spoken against the use of the solution stronger than 1 to 5,000 or 1 to 10,000 in irrigating any large cavity. He thought the warm freshly boiled water was much safer than the bi-chloride solution and equally affective in washing out the peritoneal cavity. He considered that the cases reported by Runge, Lusk and others, and referred to in his paper demonstrated the fact, that, in those cases where the cyst contents was of a thick, tenaceous character, the drainage tube was the proper treatment, and only moderate, careful sponging should be employed.

Dr. F. E. Chatard, Jr. read the following paper:

EXTRUSION OF FŒTAL MEMBRANES AT SEVENTH MONTH WITH SUBSEQUENT RETRACTION.

Mrs. B., second pregnancy; up to date of March 7th, the 33d week, nothing unusual had occurred; on that date I was hurriedly summoned and obtained from the husband the following data:

Mrs. B. had that afternoon taken a walk of considerable length, and decidedly more than was her custom, as a result she felt more than usually fatigued and complained of a sense of weight and fullness about the genitals. Her husband, who was of a rather enquiring turn of mind, made an examination and found a purplish mass protruding from the external genitals; he at once directed her to keep quiet in bed and sent for me. I saw her about three hours after her walk and in making an examination found protruding from the labia a soft fluctuating tumor, about the size of a small chicken egg; this could be traced, by the finger within the vagina and extended up to and within the external os uteri, which was dilated to about the size of a silver quarter-dollar. The tumor was nearly cylindrical in shape, moderately tense, contents perfectly fluid, with walls about the thickness of the membranes at term; there was no apparent uterine contraction at the time of my visit, no pain, and the sensations complained of immediately after the walk had almost entirely disappeared. I directed her to remain quiet in bed and if labor pains came on to check them with an anodyne mixture of chloral and morphia as she was still within six weeks of her expected date of confinement. At my visit the next morning I learned the patient had passed a comfortable night, had experienced no pains or uncomfortable feelings; the tumor had retracted so that the lower portion was about half way between the os uteri and the external genitals; directed continued rest in bed. On third day I found the tumor projecting only slightly at the mouth of the womb which was now contracted to about the size of a three cent piece. On the fourth day the os had returned to its normal size and condition, and no membranes could be felt; the patient completed her term of pregnancy and was confined on April 11th; the labor was normal, the bag of waters forming as usual. The point of interest presented by the case just related is the extreme distension of the bag of waters at this early date, and its subsequent gradual and steady retraction until it returned to its normal situs within the uterine cavity; this coupled with a corresponding steady contraction of the dilated os, and the continuance of the period of gestation makes a unique case so far as I have been able to investigate the literature of the subject. The distensibily of the membranes has abundant clinical demonstration at term and immediately preceding the rupture of the bag of waters by the efforts of nature, but the retractibility is not often made so manifest, though the possibility of such power has been demonstrated by

the researches of Baer, Remak, Vulpian and others; their invesgations have proven the existence of two layers of the amnion, an internal or epithelial layer, and an external composed of connective tissue, more condensed as it approaches the epithelial layer, and of new straited muscular fibres; it is by the presence of these muscular fibres that we can explain the phenomena which in the present case is demonstrated clinically. At the same time the history of the case conclusively proves that a marked degree of dilatation of the os, with corresponding protrusion of membranes by no means necessarily results in immediate or even proximate completion of the uterine effort, if we can by any means arrest further expulsive action; in fact the presentation of the bag of waters as here described may be considered as indicating laxity of the membranes and feebleness of contraction of some duration, a condition offering the best chance of successfully arresting the progress of a threatened premature labor before the rupture of the membranes occurs.

DISCUSSION.

Dr. F. E. Chatard, Sr., had never met with a case similar to that reported. He had always considered that any considerable protrusion of the membranes made speedy labor inevitable, and he had always acted in accordance with that idea. He now recognized that his reasoning had been wrong, and thought the case of great interest as showing to what an extent extrusion of the membranes could take place, and still the labor go on to full term.

Dr. A. F. Erich said that so far as his experience went the case reported by Dr. Chatard was unique. He suggested that the membranes were forced out by contractions of the uterus, and the subsequent relaxation of that organ allowed them to retract to their original shape. All cysts have a tendency to assume the spherical form. He thought this a more plausible explanation than that it was due to contractility of the membranes.

Dr. P. F. Mundé, so far as his experience and reading went, considered the case unique. He was inclined to think that Dr. Erich's theory better accounted for the facts than those brought forward by Dr. Chatard.

Dr. T. A. Ashby said the case reported by Dr. Chatard must be one of extreme rarity. He had never met with any similar case in his own practice, but he recalled a case which had been recently reported, and which was perhaps more remarkable in some respects than Dr. Chatard's. The case he referred to was reported to the Chicago Gynæcological Society, Jan. 13th, 1886, by Dr. H. T. Byford. The case occurred in the practice of Dr. C. R. Parke. A discharge of the *liquor amnii* took place, labor pains came on, and the umbilical cord became prolapsed. Dr. Parke replaced the cord and gave ergot. As labor did not progress, he gave morphia and the pains ceased. Three months subsequently the patient gave birth to a living child. Dr. Ashby said he considered this case unique in character, and, but for the well known reputation of the gentleman who had reported it, he would feel inclined to question the correctness of the observation.

Dr. P. C. Williams thought it very difficult to believe that there could be a rupture of the fœtal membranes sufficiently large to permit a prolapse of the cord, and yet pregnancy go on for any considerable time. Such a rupture must be central, must needs lead to complete draining of the amniotic fluid, and be speedily followed by labor. He had often seen cases in which the "waters" would escape during the recumbent position, but would cease so soon as the patient resumed an upright position. In these cases he supposed the rupture was slight, and near the *fundus uteri*. Whether the explanation was correct or not, the fact remained that the amniotic fluid might, under certain circumstances, escape in considerable quantities, and yet the pregnancy not be arrested.

Dr. H. M. Wilson referred to a case in which there was a pretty constant discharge of the amniotic fluid for two weeks before labor.

Dr. L. E. Neale thought that the presence of muscular fibres in the mem-

branes would sufficiently explain their retractility, and as this explanation was given by such authorities as Tarnier, Chantreuil (1882) and Charpentier(1883), it was worthy of consideration. Although it did not directly pertain to the case reported, he would like to elicit the opinion of the Society upon the more practical question of the treatment of the membranes during labor. Dr. Byford had recently advanced the opinion that the membranes should not always be ruptured after complete dilatation of the os uteri, but that every endeavor should be made to preserve them intact until they protruded at the vulva, with the object that they might also serve to dilate, by water pressure, the vagina, perineum and vulva. He (Dr. N.) could say nothing in favor of this opinion either from a theoretical or practical standpoint, but would be pleased to hear from the Society, and especially from Dr. Mundé.

Dr. Mundé did not agree with the teachings advanced by Dr. Byford. He thought that any advantage gained by the dilating effect of the unruptured membranes in the vagina would be more than counterbalanced by the delay in the labor.

Dr. W. E. Moseley exhibited "Searby's Douche-pan," manufactured by Tiemann, of New York, and sold by Andrews & Thompson, of this city.

Dr. Neale exhibited a modification of Braun's Cranioclast (Craniotractor, Mundé). The principal modification was in the solid blade of the instrument, which terminated in a *screw-tip* for boring through the fœtal skull, thus combining the perforator and cranioclast in one instrument. Such a modification had been exhibited before one of the European German medical societies and published, he believed, in a number of the *Centralblatt fur Gynäkologie*, 1883, and hence was not original. Dr. N. had substituted his entirely removable compression thumb-screw, at the end of the handles, for that of Braun. The instrument was for sale at Mr. Chas. Willms, of this city.

PHILADELPHIA CLINICAL SOCIETY.

STATED MEETING HELD FEB. 26, 1886.

The Vice-President, Dr. Daniel Longaker, in the chair.

NECROSIS OF THE FEMUR, NECESSITATING AMPUTATION.

Dr. Henry Peake reported the following case:

"The patient is 29 years of age, by occupation a fresco-painter. He had been perfectly healthy until the present trouble was acquired. Eight years ago he fell from a scaffolding, fracturing the right thigh, and severely contusing the hip. Three years later, after exposure to wet and cold, he suffered from a severe right sciatica, accompanied by marked muscular atrophy, which lasted eleven weeks. The muscles soon acquired their natural size, and after a few months the slight resulting looseness entirely disappeared. About one year from this a swelling appeared on the affected limb, just below the gluteo-femoral crease, which spontaneously opened and discharged pus, and two or three small fragments of bone. This was neglected for two years, when occlusion of sinus occurred, resulting from lodgment of an osseous fragment, followed by accumulation of pus, with subjective symptoms. The fragment was removed with the result of complete healing of the part. He remained well until late in the spring of '85, when he contracted a specific chancre. The constitutional phenomena manifested themselves about six weeks later, in the usual form of angina, fever, mucous patches and roseola. At the same time an excruciating pain, unaccompanied by redness, swelling and heat, developed in the right tibial head. This was most severe, and for its relief necessitated large doses of opium. After one week the knee-joint became swollen; this rapidly increased and involved the leg, the calf soon becoming tense. Free incision through the gastrocnemius evacuated about half a pint of pus, which is presumed to have burrowed its way down

behind the posterior tibial surface from the orifice in the ligamentum posticum. Notwithstanding this free drainage various openings established themselves about the articulation, and it became very evident that the limb was doomed. The patient refused radical measures until spontaneous luxation occurred, and the profound hectic, and paroxysms of exhaustion, convinced him that death was near. For several weeks the temperature range was between 100° and 102°. There were pronounced chills with profuse sweatings, and the pulse-rate continuously above 120. A huge abscess, that fluctuated on the right side of spine, about the junction of upper and middle thirds of thoracic vertebræ, and extending down behind the pelvic fascia into the gluteal region, existed on the opposite side. That this was one large cavity was proven by the fact that pressure upon either the gluteal or spinal prominence occasioned bulging at the other. In September, assisted by Drs. G. Davis, G. Faught, C. Dock and Mr. Morris I amputated the limb at the juncture of the middle and lower third of femur. The operation was followed by profound shock, from which, after considerable difficulty, reaction was established. The after treatment occupied several weeks, and embraced, in addition to the anti-syphilitic measures, evacuation of the enormous abscess. This completely healed, and the patient is now apparently well, and stouter than ever before.

Examining the specimen we find that the internal and external vasti muscles have been separated from the femur by pus, that on the inner aspect extended along the femur quite a distance. At the time of operation it was thoroughly scraped, and gave no subsequent trouble. The knee-joint is seen to be completely destroyed. The semi-lunar fibro-cartilages are gone, and even the anterior and posterior crucials.

The capsular and lateral ligaments are eroded and perforated in many places, while the transverse and coronary are not seen. Sawing through the femur, joint and tibia, we find the patella bound down to the condyloid surface of the femur, and the tibia greatly diseased. Its head is rarefied and crumbling; slight pressure breaks it down. The process involves the superior tibio-fibular articulation which is destroyed.

The medullary cavity of tibia is the seat of purulent deposits throughout its entire length, while externally at the middle of the crest is a ridge of granulation tissue.

A microscopical study of secretions, prepared by Dr. Henry Formad, discloses every evidence of an intense inflammation. The Haversian systems are completely disintegrated in many areas, and in the place of lamellæ, with lacunæ and canaliculi, are wide spaces, which, in some places are occupied by leucocytes and blood-corpuscles. Complete absorption of Haversian systems is common, while in areas where osseous structure can still be recognized, the osteo-blasts are distended, and the canaliculi correspondingly filled.

Areas occupied by inflammatory exudate and product manifest a decided tendency toward fusiform connective tissue cell developement, which is especially conspicuous about the arteries. These show a pronounced proliferation of connective tissue about their external coat, and between the intima and muscular layers. Longitudinal section of the Haversian canals discloses them to be dilated and filled with cells and where some anastomose there is a marked tendency to absorption of bone tissue.

DEATH FROM EXTRA-UTERINE PREGNANCY.

The report of the following case, with specimen, was sent by Dr. Smith, of Millville, N. J.

Mrs.——, æt. 40, one daughter æt. 19, several miscarriages since; about three months pregnant, with no unusual symptoms, was taken with a sudden pain in the uterus—supposed to be uterine colic, to which she had been subject—vomiting a good deal. Had had considerable vomiting of pregnancy. I was called and gave a hypodermic of morphia, administered bismuth and oxalate of cerium. There was nothing to arouse my suspicion of special mischief. She was

lying on the lounge dressed, so I did not examine the abdomen externally. The next day, carbolic acid and cardamon relieved the vomiting; bowels not acting, small doses of calomel followed by enema produced relief. Entire recovery followed quickly. Twelve days later I was called in haste, at noon. The patient had been sewing all morning, when suddenly she had a spasm of severe pain in the abdomen; she was carried to bed where I found her almost in collapse, pulse scarcely perceptible, face blanched. Upon stimulation she rallied, and after a careful abdominal examination, extra-uterine pregnancy was diagnosticated. She improved during the afternoon, rested quietly in the evening, and died suddenly at 5 o'clock the next morning.

Autopsy 33 hours after death. On opening the abdominal cavity we found everything afloat in blood, which being removed we found the diagnosis verified to the letter; a three months fœtus developed in left tube, sac ruptured, save the amnion, which is intact. Beyond this the uterus has several fibroid intramural tumors.

Dr. Daniel Longaker then reported a case of

ICTERUS NEONATORUM IN WHICH DEATH OCCURRED ON THE NINTH DAY.

L——, white, was born in my ward, in Philadelphia Lying-in Charity, after a normal labor, male sex and weighed seven pounds at birth. The mother had some milk at the time of delivery and the secretion soon became abundant. During the first four or five days the child nursed, but at the expiration of that time it did so very imperfectly, and a day or two later it was entirely unable to draw the milk from the over-distended glands. Icterus had, by this time, become general; the entire surface was of a deep yellow hue, as well as the conjunctivæ. The urine was scant, dark colored staining the napkin. The child was constipated but it had small stools which retained during this time, traces of the meconium. At this time, also, it was observed to have oscillation of the eye-balls with convergent squint.

There was also occasional rigidity of the muscles of the back and of the extremities. The fontanelles were all depressed and the cranial sutures could easily be seen.

The child being unable to nurse was fed upon peptonized milk; stimulants and small doses of calomel were administered. There was no difficulty in swallowing. It slept but little and its cry was aptly described by the nurse as a *whine.*

The case was regarded, from the first as of more serious nature than an ordinary case of jaundice in the new born. Death on the ninth day. Autopsy ten hours after death. Rigor mortis. The entire surface was of a deep yellow color. No evidence of peritonitis. Nothing abnormal in the fœtal vessels. The vicinity of the duodenal orifice of the cammon duct had no mark of bile. An attempt to inflate it was unsuccessful, but later after some perserverance I succeeded in passing a small bristle from the duodenum through the common into the hepatic duct. The gall bladder was apparently distended.

MARY WILLITS, M.D.,
Reporting Secretary.

URETHAN.—It will be remembered that urethan or urethane has been recommended as a hypnotic. Schmiedeberg has a most interesting article in the *Archiv für Experimentelle Pathologie und Pharmacologie*, in which he deals with the pharmacological action and therapeutics of some of the ethers of carbamic acid; urethan is the ethyl salt of this acid. Solutions containing 10 to 25 per cent. of this ethyl carbamate produce insensibility, precisely as occurs in the anæsthesia of chloroform; but the respiratory movements appear to be increased in frequency and force, a possible effect of the influence of the amidogen group; the heart appears to be unaffected by urethan. The new hypnotic cannot be used for surgical operations, but may replace the nauseous paraldehyde and chloral, where it is wished to avoid the action of chloral on the heart and respiration.—*Lancet.*

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD MARCH 4, 1886.

The President, B. F. Baer, M.D., in the chair.

MENSTRUAL EPILEPSY.

Dr. Howard A. Kelly exhibited recent specimens of tubal and ovarian disease, removed within the past two weeks. The first specimens to which he called attention were removed from a patient twenty-one years of age, who has suffered from an aggravated menstrual epilepsy from the very first appearance of the function. There was no difficulty whatever in the removal through a small incision into which two fingers could just be slipped. The whole operation from beginning to complete closure took but twenty-four minutes. The right ovary was deformed by a very prominent nodule, about one and a half centimetres in diameter, which burst on removal, discharging a watery fluid, and was shown by its lining membrane to be the last corpus-luteum.

The second specimens are rare examples of

HYDROSALPINX WITH CONGENITAL DEFICIENCY OF TUBES AND BROAD LIGAMENTS.

In this case there was malformation of the distal ends of the tubes, broad ligaments and ovaries. The left tube is as large as a bologna sausage. It was brought into view with great difficulty after separating many slight adhesions to the pelvic walls; while the isthmus is much enlarged and thickened, the great distention is at the involuted ampulla. The operator was materially assisted in bringing this tube into view by upward pressure on the cervix by a hand in the vagina. The fimbriated extremities were lost in a mass of vascular and fibrous tissue forming a broad ligament and deep down in this were imbedded the somewhat hard elongated large ovaries. It was utterly out of the question to attempt a removal of the ovaries, and any such operation would have been of a very desperate character. Nor did he, Dr. Kelly, regret this in the least, as he had planned his operation for *tubal* disease to which he attributed all the patient's sufferings. The right tube was as large as his middle finger, and was also distended with watery fluid.

The other specimen is a very large

HEMATO-SALPINX.

This tube, the left, about four inches long, burst as he was removing it, discharging four ounces of tarry blood. It was very adherent, having several attachments to intestine and omentum. The dilation is here too seen to be at the ampulla, which extended far beyond the ovary back into the cul-de-sac. The ovary is embraced by the isthmus, and presents a curious appearance as it lies, about twice the normal size, embedded in a sort of ball and socket manner below the isthmus. Where it is laid open the tube is converted into one large sac.

Dr. W. Goodell had been surprised at the size of the tubes.

Dr. Jos. Price remarked that the tube was so large that the uterus had been pushed aside by it. Great care was required in its removal.

Dr. Chas. Hermon Thomas said that some time since he should not have recognized such a condition, but now he can; the result of experience in bimanual examination. He would like to hear further on this point of diagnosis.

Dr. B. F. Baer thinks it very unfortunate that the ovaries as well as the tubes could not have been removed in the case just reported by Dr. Kelly, for their presence will probably result in the usual monthly congestion, and consequently the pain and other pelvic distress, for the relief of which the operation was performed, may continue to exist. There are several cases on record in which the tubes were removed and the ovaries allowed to remain, but the results have not been reported.

He can see no reason why this should be done unless the ovaries can not be found, or some other insurmountable

difficulty presents itself. He fully believes in the advantages of prolonged and thorough palliative treatment in these cases. Benefit usually follows, and sometimes cure; at least operation is rendered less difficult and more likely to be followed by recovery of the patient, both from the operation itself and the symptoms. Certainly the application of remedies such as iodine to the fundus of the vagina and the interior of the uterus with prolonged rest and general building-up of the system will have a strong influence in attenuating adhesions, promoting absorption of lymph and possibly, if not probably, in cure of the patient without operation.

It should not be forgotten that removal of the tubes and ovaries in these cases does not cure absolutely in every case. He believes that we will be called upon in a few years by many of these cases which have been operated upon to relieve symptoms which still exist or have returned, and for the relief of which operation had been performed; just as we have been called upon from time to time and pestered by those old cases of chronic hypertrophy and retroflexion of the uterus with pelvic adhesions. He has now under his care one of his own cases upon which he operated for the relief of symptoms, the result of disease of the tubes and ovaries with pelvic adhesions. The patient made a good recovery and appeared to have been cured, but the symptoms have returned, and she is now complaining almost as much as before the operation; she also has periodical attacks of metrorrhagia. This of course is an unusual case.

He has another patient under his care, who was operated upon in a neighboring city by removal of the tubes and ovaries, and is treating her for the same symptoms of which she had complained before the operation. He is an advocate of the operation in some cases, but he pleads for due deliberation and the exhaustion of careful palliative and preparatory measures before operation is resorted to. Many cases will get well without operation. Some will not be benefitted by operation as performed, and there is some danger in laparotomy, although Tait has had such remarkable success.

Dr. Da Costa inquired if Dr. Kelly had tried the benefits of rest and treatment before operating.

Dr. Joseph Price said that the recurrence of symptoms seemed to indicate partial removal of the tubes and ovaries. One of the fundamental rules of surgery is to seek for pus when it is probably present, and in all cases to remove it if possible. When the ligatures will cut through the tubal stump on account of its cheesy character, hæmorrhage may be prevented by the application of the cautery.

Dr. Kelly, in closing the discussion, said he did not in the least regret that the ovaries could not be removed as he had operated for tubal disease, not for ovarian, and he admired the zeal of Schroeder, who instead of always removing the ovary, sometimes resected diseased portions.

In all the cases of tubal and ovarian disease upon which he had operated, months and years of careful treatment had been wasted, and now where he diagnosticated pyosalpinx the only delay he allowed was to put the patient in the best possible condition for operation. Topical, external and internal, treatment is utterly futile, and never does more than secure temporary palliation.

Dr. Kelly's reliance regarding diagnosis lay entirely in a skilled bimanual examination, by which he always accurately mapped out all the peculiarities of the case before operation. If there is rigidity and resistance it is necessary to etherize, but he has yet to see the case where the presumptive signs were those of tubal and lesser ovarian disease, where the structures could not be picked up between the two hands and outlined. He considers that this tact has been largely developed by persistently examining the condition of the appendages to the utmost possible extent as a routine practice in all cases which come under his notice. Introducing the finger as high as possible, by forcing the hand well under the pubic arch, and carrying the sensitive pulp up against the post fornix or either lateral fornix, and then playing up and down with the other

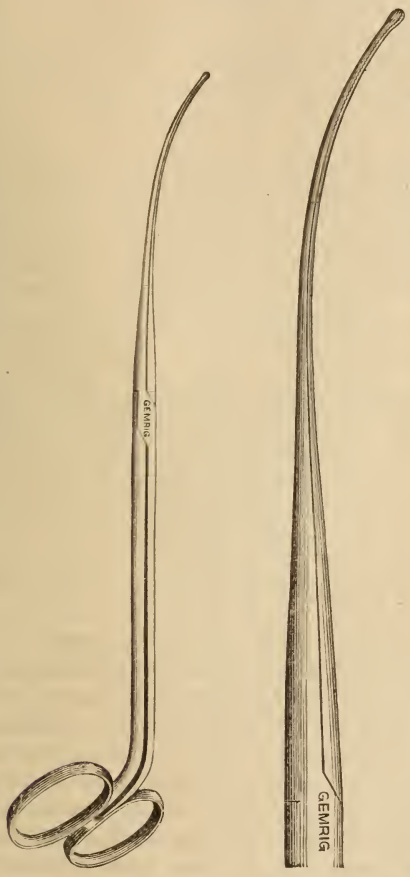
hand pressing on the abdomen, and creeping a quarter-inch at a time without ever fully relaxing, and letting structures in between roll through the two fingers, and in case of an ovary, running round its whole periphery, or of a tube tracing it up to the cornu-uteri and down into the retro-uterine pouch where it generally terminates, give often most surprising results, and would doubtless, if universally carried out, change hundreds of diagnoses of leucorrhœa, endometritis and flexions with adhesions, to the far more serious ones of pyo- or hematosalpinx.

PYO-SALPINX.

Dr. Joseph Price exhibited specimens of pyo-salpinx from two patients, and afterwards remarked that Tait and Keith have ended the dark period by showing us how to operate on the abdomen and pelvis without fear and little risk. The wonderful advance in pelvic and abdominal surgery should be placed to their credit. He believes it is now universally admitted that they have reached the very acme of perfection. One surely must be a convert to Tait's law to contend with the great difficulties in pelvic surgery: "That in every case of disease in the abdomen or pelvis, in which the health is destroyed or life threatened, and in which the condition is not evidently due to malignant disease, an exploration of the cavity should be made." Standard works on ovariotomy dwell at great length on the subject of adhesions as the most important and difficult complications with which the operator has to contend. In short in pelvic operations the risk and the difficulty will ever lie in the separation of organized inflammatory products. Adhesions when old, between the pelvic viscera and diseased tubes become degenerate and hence easily ruptured. In one case only have strong adhesions, deep in the pelvis, stayed my hand. The right tube and ovary adhered strongly to the sac and right side of the uterus, and the whole adherent mass was absolutely inseparable. Again, the rupture of pus tubes or cysts filled with inflammatory, septic or malignant elements, will be followed by serious symptoms. Operation becomes difficult when the ovaries and tubes, tightly distended with pus, and softened through pathological changes, cheesy in consistence, are matted together with the rectum and small intestines.

UTERINE APPLICATOR AND DRESSING-FORCEPS COMBINED,

exhibited by *Dr. Charles Hermon Thomas.* This instrument, which is specially adapted to making applications within the cavities of the neck and body of the uterus, but which is also available for making dressings and applications to the vagina and external surface of the cervix, has borne the test of two years use. It is in forceps form; the blades are strong and resistent from the handles forward about two-thirds of their length, when they narrow rapidly, so that taken together they become about equal in size to the ordinary uterine sound. This narrow portion, somewhat suggestive of the long beak of the angular ear forceps, is about three and a half inches in length, the tips being roughened on their opposed surfaces. It holds securely the smallest pledget of cotton, and by reason of the springy character of the beak will permit the locking of the handles when a full-sized pledget or tampon is placed within its grasp. The point is slightly probed as an extra precaution when introduced to the uterine fundus, though a small cotton ball answers all needful purposes as a protective tip. I have usually employed the plain point on account of its occupying less space at the internal os-uteri. The beak is curved to a shape corresponding very closely to that of Ellinger's dilator, and which has been found so generally well adapted to entering the uterus. This portion is electro-plated with gold, when so ordered, (a proceeding of moderate cost, and to be commended) as a protective against the corrosive action of iodine, iodized phenol and the like which so rapidly destroy nickel-plating and corrode polished steel surfaces. The instrument was made under my directions by J. H. Gemrig & Son of this city.



Some practical points of use may be mentioned. Soiled or medicated cotton is easily removed with the use of one hand only by simply unlocking the handles and wiping the point in a crumpled paper, thus leaving the other hand free for other employment and avoiding the trouble, the soiling of the fingers and the whittling often involved when the wire applicator is used. In its use there is immunity from the raspaction of the closely wrapped cotton of the wire applicator, and also a greatly increased carrying capacity of the cotton for medicated liquid. Moreover it will be convenient and desirable to make use of the instrument as a uterine sound incidentally in certain instances. In my own experience it has proved praticable as an applicator, one fully meeting the needs of most cases; while as a uterine dressing forceps for general use it has been found so satisfactory as to have superceded all other instruments of this class.

Dr. Baer said the instrument presented by Dr. Thomas is a very ingenious one and will doubtless serve a good purpose where the cervical canal is patulous; a greater quantity of the medicating agent used can be carried to the diseased surface than when the tightly wrapped cotton is used.

Dr. J. F. Wilson has nothing to add to what Dr. Thomas has said. He has used one for several months and can agree with Dr. Thomas as to the ease of application and removal of soiled cotton.

Dr. Parish said that the forceps was valuable and would be much used. As an applicator it will be very convenient. A few years ago the sound and applications were too much used, but extremes either way are wrong. Applications to the endometrium are sometimes needed.

Dr. H. A. Kelly said this is a very valuable instrument.

Dr. Parish exhibited a specimen of

OVARIAN TUMOR

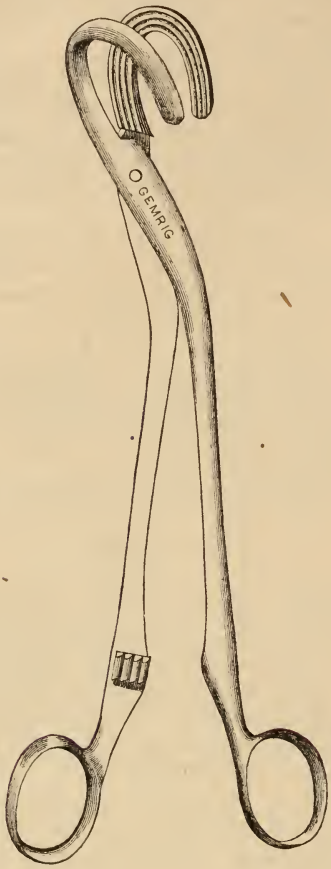
removed the previous day. The symptoms had been very peculiar and the form of the abdomen was mis-leading, there being a deep groove across the hypogastric portion of the tumor. Numerous adhesions gave great fixity. These adhesions embraced the colon, parietes and bladder, and were old and dense. Its rapid growth had raised a question of malignancy. A great portion of the tumor was solid.

Dr. Harris remarked that a microscopic examination of the tumor should be made. There had been great difficulty in diagnosis as to the origin and character of the tumor. A slight fluctuation could be detected in the lower portion under the use of an anæsthetic. There had been no uterine symptoms, and menstruation had been regular. The long Fallopian tube crossed the tumor and made a deep constriction across its middle.

Dr. Baer did not think rapid growth a proof of malignancy. He had seen five or six cases of very rapid developement, one in three months contained a bucketful of fluid. In none of these

cases has there been any return or other sign of malignancy. The presence of papillomatous growth within the cyst is no proof of malignancy.

Dr. Joseph Price exhibited a



FORCEPS

for the complete closure of the trocar puncture in ovariotomy.

W. H. H. Githens,
Secretary.

Correction.—Dr. W. P. Chunn wishes the following correction made in his paper, which appeared in the issue of this Journal of March 27th, 1886: On page 421, first column, line 37, read "fibro-cystic disease" for "ovarian disease."

Benzoate of Cocaine.—Señor Alfredo Bignon, in a paper read before the Lima Academy of Medicine, and published in *La Cronica Médica*, strongly recommends the employment of the benzoate of cocaine in preference to the hydrochlorate (the salt most commonly used), and to the salicylate and borate, with which he has also made experiments. He finds that the benzoate is extremely soluble, easily crystallisable, and retains the characteristic odour of coca itself. The antiseptic qualities of benzoic acid also are an additional advantage. Amongst other experiments, the anæsthetic effects of a 20 per cent. solution of the benzoate were compared with those of a similar solution of the hydrochlorate in a case of epithelioma of the tongue, with the result that the effect of the former salt persisted for a much longer time than that of the latter.—*Lancet.*

A Well-Merited Expression.—Dr. Lemuel J. Deal, Professor of Chemistry, Pennsylvania College of Pharmacy, contributes his views of Listerine as follows: "I have been *compelled* from its real virtue to use it somewhat extensively, and must admit it to be an exceedingly valuable addition to our materia medica. From one case of ovariotomy to over a hundred cases of nasal catarrh, I have used it with marked good results, yet if of no other service, Listerine would deserve highest commendation on account of its gratefulness as a hand-wash after general gynecological practice."

A Portuguese Method of Treating Ringworm.—Ringworm of the most obstinate character may, according to Dr. Saerlis, writing in the *Medicina Contemporanea* of Lisbon, be cured in ten days by cutting the hair from the affected spot pouring turpentine on it, letting it run over the whole head, and rubbing well with the finger. After this has caused a smarting sensation for from three to five minutes, it is washed off with carbolated soap. Hot water is then used for washing the whole head, and the affected spots touched with dilute tincture of iodine, or with a 2 per cent. solution of iodine and turpentine. This process is to be repeated once or twice a day.—*Br. Med. Journal.*

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BALTIMORE, APRIL 3, 1886.

Editorial.

RUPTURE OF THE LIGAMENTUM PATELLÆ AND ITS TREATMENT BY OPERATION.—Backed by the well recognized safety of antiseptic precautions surgeons are becoming more and more bold in bringing within the scope of operation one after another of the injuries and results of injuries which were formerly considered out of their reach. Peritoneal and joint surgery might almost be characterized as separate and distinct modern additions to the science, and the experience gained in their cultivation in recent times has doubtless added many years of life and much increased usefulness to patients with affections of those parts. Moreover, the future promises even more brilliant successes than have been achieved in the past, and the perfection of antiseptic technique, which must come with enlarged experience, will bring these and other hitherto surgically unknown regions more and more within the scope of operative surgery. Professor H. B. Sands, of New York, has lately (*Annals of Surgery*, March, 1886,) made an elaborate study of rupture of the ligamentum patellæ, and at the conclusion of his paper reports a case in which he successfully sutured the ligament in a patient who otherwise would have been a cripple for life. The injury is sufficiently rare to make Professor Sands' study very valuable scientifically, independent of the practical conclusion at which he arrives. He adds records of thirteen cases gathered from the records of the New York Hospitals to the sixty-five which Maydl had been able to collect. The rarity of the injury as compared to fracture of the patella is given as follows:

	Fracture of Patella.	Rupture of Lig. Patellæ.
N. Y. Hospital	150 cases.	3 cases.
Bellevue "	140 "	7 "
Roosevelt "	44 "	2 "
St. Luke's "	19 "	1 "

The injury is sparingly discussed in most of the standard surgical text-books, and little is to be learned about it save that the rupture of this tendon and of the triceps and tendo Achilles are the ones most like to occur and that they are to be treated on the general principles of rest and extension. Erichsen disposes of the whole matter in a dozen lines. P. S. Conner, in the International Cyclopedia of Surgery, devotes a few lines to its discussion, and proposes suture. J. Lockhart Clarke, in Holmes' System, quotes Paget and recommends extension and bandages from above downwards. Prof. Sands' tabular statement of the thirteen cases, previously referred to, including his own two, one of which was operated upon, is a valuable addition to the literature of the subject.

The case upon which Prof. Sands operated was one in which eight months had passed without restoration of function, and the operation was made difficult by the retraction of the quadriceps, which had to be incised in many places. The history of the case was uneventful except that for some days after the operation the patient suffered much pain. The operation was successful, the last report of the case showing extension to the normal limit, flexion to right angle, the patient being able to go up and down stairs without assistance. This is the first modern case as far as Prof. Sands has been able to discover. "Maydl states that in a posthumous work by Veslingius (*Obs. Anat. et Posthum*), published in 1740, he found a notice of a case in which tenorraphy of the ligamentum patellæ was performed with success." Prof. Sands does not propose

the operation in all cases of tendon rupture, but looks forward to the time when it will be the general practice. Speaking of the hesitation still felt in opening into large joints, he says: "I confidently anticipate the time when skillful and careful surgeons will be able to divest it of all danger to life or limb; and whenever this period arrives, our time-honored, but clumsy, tedious and uncertain method of treating both fracture of the patella and rupture of its ligamentous attachments may well be abandoned in favor of some form of operation calculated to secure an immediate union of the divided parts."

Mortality from Puerperal Fever Before and Since Antisepsis.—No careful student of Obstetric literature can fail to observe the great reduction of mortality from puerperal fever during recent years. This diminished death-rate may be referred to several causes, but the most striking influence at work in the accomplishment of this result must be referred to the practice of antiseptic methods.

As far back as 1847, Semmelweise urged the necessity of washing hands in chlorine water before examining lying-in women. At that time Semmelweise was acting as first assistant to Professor Klein. It is stated that the learned Professor laughed at his assistant's proposition, but, at the same time, gave the order. Semmelweise's investigations at the time were harshly criticised and he was regarded as a medical crank. In this respect he fared no worse than Jenner, Lister, McDowell, and, later, Pasteur and Koch, to all of whom the world is indebted for the eccentricities of their peculiar methods and practices. Semmelweise was not long in demonstrating the results of his antiseptic precautions. Prior to 1846 the mortality in the Maternité hospitals in Paris, Vienna, and other cities, was at times enormous. We are indebted to the Vienna correspondent of the *Journal of the American Medical Association* (March 20th,) for the statistics of the Vienna hospitals before and since Semmelweise's views were adopted. In 1823, during the epidemic of puerperal fever in February, March and April of that year, there were 698 confinements, of which 133 died. In 1842 there were 3,287 confinements with 518 deaths, and as late as 1846 out 3,352 confinements 459 died. The year following, 1847, Semmelweise's methods came into practice and the mortality for this year was 176 out of 3,375 confinements. In 1848 the mortality fell to 45 out of 3,556 confinements. In 1854 only 40 deaths occurred out of 4,393 confinements. The statistics of Prag are still more remarkable. From 1865 to 1878 the Old Maternité laying-in building, which was entirely unfit for purposes of hygienic detail,was used. The mortality during this period was 6.69 per cent. In 1875 the new building was completed and the mortality from 1876 to 1884 fell to 0.65 per cent. These facts cannot be controverted. They show the eminent value of absolute cleanliness in obstetric practice and the great importance of enforcing strict antisepsis in obstetric work, whether this work be conducted in meternité institutions or in private practice. We are led to infer that strict antisepsis consists not so much in enforcing uterine and vaginal irrigation with antiseptic fluids as in the cleanliness of arms, hands, nails and clothing during attendance upon confinement cases, and in avoiding the introduction of diseased germs from cases having zymotic diseases. Whilst every care should be employed to prevent anto-genetic infection the obstetrician should be equally sure not to introduce hetero-genetic infection as well. It is by close attention to antisepsis in the full acceptance of this term that the death-rate from puerperal fever has fallen from a mortality of about 20 per cent. in 1823 to 0.24 in 1884.

Miscellany.

The Influence of Kairin, Thallin, Hydrochinon, Resorcin, and Antipyrin on the Heart and Bloodvessels.—Chemists, for a number of years, have been industriously experimenting,hoping to find a way to produce quinine artificially. The result has been the dis-

covery of a number of substances, some of them belonging to the phenol series of organic compounds, and possessing to an eminent degree the power of reducing hyperpyrexia temperatures. Of these, kairin, thallin, hydrochinon, resorcin, and antipyrin, have all been found to reduce abnormal temperatures to a greater or less degree, in almost all febrile disorders promptly, though perhaps not permanently. An experimental inquiry into the probable relations of these new antipyretics to the circulatory apparatus has been made by Dr. H. G. Beyer, and the results, which he gives in an elaborate article on the subject in the April number of *The American Journal of the Medical Sciences*, justify the attempt to solve the problem.

The experiments have been arranged into two groups: I. Experiments on the work done by the heart when isolated from the central nervous system. II. Experiments on the bloodvessels: on the flow through the vessels of animals the brains and spinal cords of which had been destroyed; on the lingual vessels of curarized frogs. In addition to this, a short account of the influence of these drugs upon the corpuscular elements of the blood and the coagulation of blood is given.

Dr. Beyer's experiments show that kairin reduces temperature, both by diminishing heat production and by increasing heat radiation. The distinctive influence it exerts on the red blood-corpuscles, however, and the weakening effect upon the heart, render its employment objectionable and dangerous.

Thallin, like kairin, reduces temperature by diminishing heat production, and by increasing heart radiation; as an antipyretic it is less dangerous, but no less objectionable, than kairin, for while its effect upon the ventricle of the heart is less depressing than that of kairin, its influence upon the blood-corpuscles is sufficent to condemn it.

The action of hydrochinon is similar to that of kairin and thallin. Resorcin reduces the temperature by increasing heat radiation by the dilatation it produces in the capillaries and veins, especially the latter.

Antipyrin reduces temperature purely by increasing heat radiation, owing to its extensively dilating the veins and capillaries; but what stamps it as an excellent antipyretic is that, besides dilating the veins, it also has a tonic influence on the heart and slightly increases arterial pressure, or, at any rate, does not cause a diminution of the same. It has, moreover, no injurious influence on the blood or the muscular tissues, and strengthens the auricles.

The objection to the employment of kairin and thallin as antipyretics arises from the fact that they cause heart paralysis, especially affecting the auricles, in doses only slightly larger than are sufficient to produce a lowering of the temperature. But this objection becomes an absolute danger when we take into account the destructive influence upon the blood-corpuscles and tissues generally.

Hydrochinon and resorcin, although not exerting the same weakening and directly paralyzing influence upon the ventricle of the heart which is peculiar to kairin and thallin, both paralyze the venous side of the heart, viz., the auricles, and greatly lower the tone of the walls of the veins. The extra amount of blood, therefore, which is driven into the veins through the increased action of the ventricle, is only with great difficulty returned to the ventricle, and here the danger is not so much from failure in the power of the ventricle as in the case of kairin and thallin, as from the danger of *bleeding the animal to death into its own veins.* The intense visceral and especially pulmonary congestion found post-mortem, by Dujardin-Beaumetz, and others, in animals killed by resorcin, seems to confirm this view of the matter.

Antipyrin, though largely dilating the veins, increases the power of contraction of both auricles and ventricle, and has no injurious influence upon the blood nor the muscular tissues, and therefore possesses, indeed, all the good qualities of a perfect antipyretic.

Professor Billroth, the distinguished surgeon, it is stated, has gone to Egypt on account of his health.

Medical Items.

The late Dr. Austin Flint, Sr., has willed his medical Library to the New York Academy of Medicine with the exception of such books as his family may wish to retain.

The *Philadelphia Medical Times* proposes the name or Dr. J. M. Da Costa for the Presidency of the Ninth International Medical Congress, to fill the vacancy occasioned by the death of Dr. Austin Flint, Sr.

At a recent meeting of the London Pathological Society, fifty cerebral tumors were exhibited by members, the size, location, and morbid condition of which were almost as varied as the number presented.

Mr. Joseph Pulitzer,the proprietor of the *N. Y. World* and a member of Congress from New York, has given his first year's salary as Congressman, $5000, to the New York Hospital, to found a free bed for the benefit of newspaper men.

Col. Waring has accepted the invitation of Executive Committee of the Medical and Chirurgical Faculty of Maryland, to deliver the Annual Oration, April 28th inst., at 12 o'clock M. The tittle of his address is "The Removal and Destruction of Organic Wastes."

Mr. Cooper Forster, a well-known London Surgeon and a man of considerable prominence and influence, died recently from exhaustion after a few days illness. Mr. Forster was President of the College of Surgeons last year. He was 61 years of age.

The *London Lancet* says: "We understand that the College of Physicians and Surgeons of Edinburgh and Glasgow have decided to throw open to women their conjoint examinations and triple qualification in medicine, surgery, and midwifery."

According to Dr. H. C. Wood, John Bunyon' the author of "The Pilgrim's Progress,"suffered from monomania with depressing delusions. We are led to infer that it was during one of these fits of depressing delusions that he wrote one of the most popular and widely read books ever published in the English language.

A commission appointed by the Academy of Sciences has decided upon the establishment of a *locale* in Paris for the treatment of persons bitten by mad dogs. It is to be called "Institute Pasteur," and is to be supported by public subscription. As it is intended to be international, subscriptions are solicited from all parts of the world.

Urethan seems to grow in favor as an excellent cerebral hypnotic and to possess advantages over the usual hypnotics in the fact that it is well borne, produces no unfavorable symptoms and causes physiological sleep. The minimum dose is 15 grains, but it may be increased to 60 grs. without danger. It should be given in capsules or in watery solutions with some syrup to correct the taste.

Pasteur has treated over 350 cases for the prevention of hydrophobia. Of this number the first 200 cases have been submitted to the preventive inoculations more than two months ago. Of these 200 cases of certified bites from rabid dogs not one has been followed by hydrophobia. M. Pasteur considers that this test in confirmatory of the success of his inoculation experiments.

The *Medical Record* asserts that the affairs of the next International Medical Congress are not in a promising condition. "There is apathy and discord at home, a state of doubtfulness and expectancy, to put it mildly, abroad." It is also stated that the death of Dr. Flint and the illness of Dr. Davis are additional blows to those who appear to wish to rule the Congress on an association basis, or ruin it.

The *Medical Record* says: "One of the most versatile of medical men of the present day is Sir Henry Thompson. He attained eminence many years ago in his own profession, specially distinguishing himself in the field of urethral surgery. He is also well known as an artist, having frequently been an exhibitor at the Royal Academy. He is not unknown as a writer and speaker, having on several occasions championed the cause of temperance reform. He is now busy with a new novel, and bids fair to attain equal renown in the field of romance."

Queen Victoria has graciously smiled upon the medical profession in England, by attending in person the exercises in connection with the laying of the foundation stone of the new Examination Hall, erected on the Thames Embankment, for the use of the Royal College of Physicians and the Royal College of Surgeons. This act of Her Majesty has called forth the statement from *The Lancet* that, "Looking to the history of medicine, it is manifest that the art of healing and the enterprise of its professors have uniformly owed more—far more—to Royal favour than to Parliamentary aid or patronage."

M. Doleris has found that some specimens of the urine of patients with puerperal eclampsia give, on drying, crystals whose composition is at present undetermined, but which ares lightly soluble in alcohol and soluble in acidulated water, and a somewhat concentrated solution of which injected into animals killed a rat and three sparrows, while comparative experiments made with a portion of solution containing no crystals produced no effect. M. Doleris found a normal amount of urea in the blood of two patients dead of the disease, but an increased amount in that of two others who were cured. In one case only were soluble and toxic ptomaines met with. He believes that puerperal eclampsia is of an infectious nature, for it is not only the kidney which is affected but other organs, the liver in particular presenting characters more or less allied to those noted in acute yellow atrophy. —*Lancet* March 13th, 1885.

Original Articles.

CARIES AND NECROSIS OF ALVEOLI OF RIGHT SUPERIOR MAXILLA AND CHRONIC INFLAMMATION OF ANTRUM, DUE TO EXCESSIVE SALIVARY CONCRETIONS AND A NEGLECTED PULPLESS MOLAR.

BY B. MERRILL HOPKINSON, D.D.S., M.D., OF BALTIMORE.

I have had in the course of my practice during the past few years, what would seem to be, to judge from the experience of others, a large number of cases of disease of the maxillary sinus. With few exceptions, the disease has been devoid of active symptoms, at the time I found it, the inflammation being of a chronic nature and showing itself either in the nasal cavity, or in the throat, rather than in the oral cavity and in connection with the dental organs. I have generally discovered these troubles in operations upon the teeth, either in extractions of teeth or roots, or in the treatment of these organs when in a pulpless state. The finding of incrustations of salivary calculus upon the teeth is of daily, almost hourly occurrence, and it is most surprising how great the accumulation may be, without ordinarily producing serious injury. The appended case, of which I give a record below, is one of those rare instances where caries and necrosis of the alveoli, together with antrum disease and its attendant evils, may be caused by great accumulations of calculus, complicated with a neglected pulpless tooth. I have never seen a similar case recorded, and I think it most interesting for several reasons. I wish it were possible for medical men in general practice to be a little better acquainted with the diseases treated by oral specialists. It would indeed be a good thing for suffering mankind, and I am sure that thousands of patients would yearly save their valuable organs of mastication, and also be saved a great amount of unnecessary pain if such were the case. I have my attention called to this defect of education, as well as of study, time and again; and in the case below the young man had been variously treated, without lasting benefit of course, for general debility, malaria, &c., *ad infin.* before I was so fortunate as to discover the true cause of his trouble when he applied to me for oral services. The usual symptoms of antrum disease were absent; there did not seem to be any special indication, from an oral inspection, that would lead one to anticipate the finding of a bone lesion; indeed it was an obscure case, and yet the simple removal of salivary incrustations, as well as a tooth broken down with caries and containing a dead pulp, made the diagnosis clear, and placed the man in a condition to recover his health and strength. I would most respectfully suggest that general practitioners pay more attention to the condition of the mouths of their patients, and advise a more frequent calling upon the dental surgeon; for I am fully convinced from experience and observation that nine-tenths of those suffering from general maladies would be greatly benefitted by such visits, and the services of each would aid the other.

Mr. S., office clerk, bilious-nervous temperament, æt. 21, consulted me June 18, 1885, concerning his oral cavity, which was sadly in need of treatment. Notwithstanding the fact that he is a young man of good education and surroundings, he had neglected his mouth in a shameful manner, the result being vitiated secretions, most imperfect mastication and consequent indigestion, and a general condition of ill-health. He complained of pain of a general character, and it was difficult to localize any particular lesion, on account of the wretched condition of a number of teeth, and the fact of there being no special soreness or tumefaction present; but, from symptoms as described, and having found pus mixed with the nasal secretions, and detected a bad odor not due to carious teeth, I diagnosed, together with dental troubles, disease of a deeper seated nature than that of simple caries of these organs, and began to look elsewhere for the principal seat of his difficulty. After careful ex-

amination into his history I eliminated specific disease. He was very anæmic, complained of weakness, anorexia, and inability to apply himself steadily at his avocation; was habitually constipated; thought, as most of the sick laity do in these days, that he was suffering from aggravated Bright's, and was generally miserable and depressed. A prominent symptom was profuse and obstinate epistaxis principally from the right side, that nostril being almost continually occluded, save at these periods. I immediately proceeded, as the first step in local treatment, as well as an aid to diagnosis, to condemn and advise the extraction of seven teeth, and having the concurrence of my patient commenced operating. I removed five teeth with the patient in a conscious state, and without the aid even of a local obtundent, but so soon as I arrived in turn at the superior right second molar, he suddenly refused most positively to have me go on, saying that he had an indefinable fear of having that and the adjoining tooth removed, unless he was first rendered unconscious. There were no external evidences of disease, save enormous incrustations of salivary calculus, and unhealthy appearance of the gums, due to that cause; but, persuasion being useless, I allowed him to inhale a suitable quantity of nitrogen monoxide, and, first having removed a sufficient amount of the calculus, applied the forceps to the second molar and with surprising ease removed it, brought with it an inch of the alveolar border, loosened the third molar, and left the gums hanging like two curtains uninjured. I immediately removed the third molar, which brought with it a portion of diseased alveolus, leaving the gums as before, there appearing to be no connection between them and the bony parts which came away.

Immediately following extraction came a profuse flow of blood mixed freely with offensive pus, giving unmistakable evidences of necrosis. His reaction, as is the rule when N_2O is administered, was rapid, complete and satisfactory. I explained to him the condition of affairs and commenced a careful examination with a view of discovering the extent of the disease. I found I had removed the alveolar border entire, down to the body of the bone to the extent of about one and one half inches. I proceeded to remove all further discoverable portions of carious bone, carefully washed the parts with a carbolised solution, and in continuing my examination found that a probe could be easily passed through quite a large opening into the antrum and injections through the opening found their way most readily into the nasal cavity. I found here then the seat and principal cause of all his trouble. This state of things had evidently existed for some time and he was quite unaware of any disease of the parts, anything more than a general uneasiness which he attributed to a carious tooth. The removal of the calculus and tooth removed, of course, the cause of the disease, made a diagnosis sure, and laid the foundation for permanent general improvement. Everything seemed favorable for successful local treatment, the tendency to hæmorrhage seemed *nil*, there being very little bleeding since the first gush after removal of the teeth, and after thorough injections with a tepid carbolised solution, two per cent., a suitable dressing of absorbent cotton, saturated with the solution to keep the wound patulous, permit drainage and prevent sepsis, which dressing the pendent gums enabled me to apply satisfactorily, I dismissed him for the day, and enjoined him to remain as quiet as possible and to return next day. Before leaving I prescribed a pill to be taken daily, or on each alternate day as required, at bedtime, containing res. podophyl gr. $\frac{1}{6}$, aloes aq. ext. gr. $\frac{1}{3}$, to regulate his bowels, told him to bring me a sample of urine for examination, which I afterwards found to be normal, and this fact enabled me to aid him in dismissing from his mind the awful bugbear of morbus Brightii. On the following day, I found that he had disobeyed my injunction to keep quiet, and had managed to get my dressing displaced, and in so doing had caused a slight hæmorrhage which alarmed him, and he applied immediately for professional services in the locality in which he happened to be. My worthy

friend and brother succeded in stopping the hæmorrhage, and also, in doing just that which I desired most to avoid, viz: using a solution of an iron salt, and plugging up the cavity so tight that proper drainage was completely arrested,and my young man presented himself in a sorry plight with a very swollen face. I removed the great mass of cotton causing hæmorrhage again, but it was easily overcome by tepid injections, thoroughly injected the antrum and other diseased parts with solution as before, renewed the dressing of the previous day, and also my injunction as to quiet. I am of the opinion that the use of Monsell's solution as a styptic is seldom required in oral, or indeed in general practice, and it should be avoided when possible, the formation of an insoluble clot followed by sloughing naturally causing a retardation of the healing process. The same local treatment was continued for nine days with very satisfactory results and the progress towards recovery was remarkably rapid. The pills operated very kindly and after four days it was only necessary to repeat them on each alternate day. I prescribed for him tr. ferri. muriat. gtt. x et quiniæ sulph. grs. ij to be taken thrice daily; at the end of the nine days I omitted the dressing, previous symptoms had disappeared, and he was in condition to have seventeen fillings inserted in his remaining teeth, which operations I commenced shortly after. On October 29,or a little over four months from first operations, I inserted for him a partial superior denture, filling all vacancies, which he is wearing with much comfort, and is now in full possession and enjoyment of good health. The diseased tooth I found upon examination to contain a mummified dead pulp, the roots were greatly exostosed, in fact, were three times their normal size, judging from the size of roots of his other teeth, were firmly adherent to their alveoli, and the palatine root had evidently penetrated the antrum. There were no signs of alveolar abscess. This case demonstrates clearly two things; first, that excessive salivary concretions may do a great deal of harm, though such cases are most rare, and that when calculus is present upon the teeth it should invariably be removed. Secondly, that it is dangerous to leave a pulpless tooth in the dental arch *unattended to.* I will say in conclusion that the latter class of teeth, of which the dentist finds a great many, may *by proper treatment* be made wholly innocuous, and put in a condition to perform their proper functions with perfect comfort and satisfaction for an unlimited number of years. I speak decisively and authoritatively on the subject of pulpless teeth, from the fact that I have read during the past year extracts from papers of a prominent physician in which he condems what *he* calls "*dead teeth*" in a wholesale and finished manner. Such condemnation is not due to ignorance, but to lack of a critical examination of the subject. Pulpless teeth are not *dead*, they have only lost their inner life, that of the pulp, and still receive adequate nourishment through the periosteum to preserve their vitality,in part,indefinitely. If they were *dead*, the condemnation of my learned brother would be just, and if not removed by the specialist, nature herself would not tolerate them but would cast them off as bodies, foreign to the animal ecnomy.

REMOVAL OF A SPLINTER OF WOOD FROM THE ORBIT.*

BY HIRAM WOODS, M.D.,

Assistant Surgeon at Presbyterian Eye and Ear Hospital.

The lodgement of a large foreign body within the orbit, without inflicting damage upon the eyeball, is an accident of rare occurrence. The following case came under my care in October 1884.

W. H. Jr., 12 years of age, was brought to me on account of an "abcess in his lower lid." His father told me that *six weeks* previous to his visit, his little boy was playing about a house in process of building, when he was struck in the face by a piece of shingle thrown obliquely from above.

*Read before the Baltimore Academy of Medicine March 16, 1886.

The boy was looking up at the time. The father pointed to an open wound in the lower lid of the left eye, just below the margin of the tarsal cartilage, and about two lines from the external orbital angle, and told me that this opening had been there since the day of the accident. The boy ceased to complain of pain after two or three days, but this wound did not close. About two weeks before the boy was brought to me, pain had returned, and with it there was considerable swelling of the lower lid. Poultices had been applied, and I found a copious discharge of pus from the original wound, and from a second small opening lower down and nearer the centre of the lid. I thought I could feel a foreign body under the conjunctiva, but the father was sure that no splinter had entered the orbit. The wound was painful, and the boy would not allow me to use a probe. The following day Dr. C. A. Cook kindly came to my office and gave bromide of ethyl for me. On passing a probe into the more external of the two wounds, I felt the splinter lying on the floor of the orbit. It was easily removed after I had enlarged the original wound,and measured a little over one inch long and fourth inch thick. I did not re-introduce my probe, as the effects of the ethyl had passed off by the time I had removed this piece, and I did not care to renew the anæsthesia. The wound, however, did not heal, and one week after my first operation, I re-examined the wound under ethyl. After a careful search I found a small piece of wood less than third of an inch long, and as thick as the end of a lead pencil, near the internal angle of the orbit. This was removed, and the boy soon got perfectly well. I saw him last summer. There is a linear scar in the folds of skin of the lower lid,but there is no ectropion. The motions of the eye-ball are unimpaired.

Small foreign bodies as shot, pebbles, etc., are occasionally embedded in the orbit and remain there indefinitely, doing no harm at all. Some curious cases are reported in which the foreign body remaining in the orbit and causing no trouble, has been of great size. Soelberg Wells and Juller each mention the case, first reported by Mr. Brudenell Carter,of a hat-peg three and three-tenths inches long entering the orbit and causing no trouble for about 20 days, when it was drawn out through the orbit. The case is narrated more fully in Lawson's "Injuries to the Eye, Orbit and Eyelids." The supposition of the surgeon who saw the case seems to have been that the peg entered "the antrum of the oppo site side." There was certainly not room enough for it in the orbit.

By far the more usual sequel of a foreign body entering the orbit is the occurrence of orbital cellulitis or periostitis. If the inflammation involves the deep orbital cellular tissue, there may be, after the formation of pus, protrusion of the eyeball, impairment of the motives of the eye, and optic neuritis from the great pressure to which the nerve is subjected.

In removing the foreign body Soelberg Wells thinks that it is generally better to make an incision through the *conjunctiva* than through the skin of the lid. This is to avoid the ectropion which might follow the contraction taking place during the healing process. In the case I have narrated above, the two openings *already* in the skin made it unnecessary to open the conjunctiva.

THE USE OF THE MAGNET IN MEDICINE.

A Historical Study.

BY J. R. QUINAN, M.D., OF BALTIMORE.

The peculiar property of certain oxides of iron, to attract iron, and impart to the latter its own powers, was well known to the Greeks and Romans, from a very early period, as shown by their references to such ores under the names of the Heraclean, Lydian, or Magnesian stones, all three designations being derived from the localities where the ore was found. That the term Magnet is derived from Magnesia, a city of Lydia, (now Manissa, in Turkey in Asia) we have the authority of Lucretius (*De Rer. Natura*, Bk vi.) whose words are:

"*Quem Magneta vocant patrio de nomine Graii, Magnetum quia fit patriis in finibus ortus.*" Plato (*Ion*, 333.) says, however, that "Euripides first gave it the name Magnet, but most persons call it the Heraclean stone."

Cicero also (*De Divinatione* 1, 88) refers to it in the following words: "*Magnetem lapidem esse dicam, qui ferrum ad se alliciat et attrahat*," and the Elder Pliny (*Hist. Nat.* xxxvi c 25) describes the different varieties of the magnetic ores, distinguishing five kinds, viz. the Ethiopian; that from Magnesia in Macedon; the Boeotian; the Alexandrian in Troas and the Magnesian in Asia, and that he considers the blue colored as the best. Fond of the marvellous, he quotes Nicander for the assertion that the Magnet derives its name from the fabulous Magnes, who discovered it, by the adhesion of the ore to the nails of his shoes as he walked over it. (?)

Whether the ancients recognized the *polarity* of the Magnet, is a moot point, though the lines of Lucretius (*op. cit.* 934-945 and 1033-1078) which freely rendered, read: "Oft from the Magnet too, the steel recedes, Repelled by turns and then attracted close, etc.," seem to give some color to the idea that even its polarity was not unknown to them.

The word *adamant*, from the Greek *a-damao* (not to be broken), and applied by the classic writers to the hardest substances as steel, or to the diamond (a word by the way, itself derived from adamant for which see DuCange, *Gloss sub-voce*) came to be used by the late Latin writers for the Magnet, on the supposition that its etymology was the Latin *adamare* (to be drawn towards by instinctive love, referring to its property of attracting iron), and our English writers, till the seventeenth century, continued to use it as a synonym for magnet, which the French do to this day in the contracted form, *aimant*. In illustration of this fact, Chaucer (1340-1400), in his "Romance of the Rose," (c 1400) says: "Right as an *adamaund iwys, can draw-en to hym sotyly the yren.*" Caxton (1481), in "the *Myrrour*" (ii. vii. 79), says: "In yonder growth the adamant stone, she by her nature draweth her yron." Shakespear (1590), in "Midsummer Night's Dream," (ii. i. 195) makes Helena say, "You draw me, you hard-hearted adamant. . But yet you draw not iron, for my heart is true as steel." Bacon (1625), in his Essays, (xviii) speaks of a "great *adamant* of acquaintance," and our own old, quaint, Increase Mather (1684) says in *Rem. Prov.* 73, "there is a certain stone called pantarbe which draws gold into it, as does the *adamas* hair and twigs." This is perhaps the latest use of adamant for the magnet, by an English writer. The word loadstone of our forefathers, is, as is well known, derived from the Anglo-Saxon, *laeden* to lead, *e. g.* the lode star —the leading star.

Pliny (*op cit. ut supra*) tells us the vulgar name for it in his day, was 'lapis vivus,' livestone, and the mysterious properties—mysterious still, notwithstanding the investigations of modern science—were well calculated to suggest the name. Indeed, we find even the grave Plato, assigning the possession of a soul to the magnet. For in addressing a poet, (*Ion* 533, see also *Timaeus* 80, c) he says, "Your (poetic) gift is not an art, but an *inspiration;* there is a *divinity* moving you like that in the stone which Euripides calls the magnet." Pity that the Greek Philosopher, could not himself have had the inspiration of dodging the difficulty, and of explaining the *ignotum per ignotius*, as we moderns do, by simply calling it, magnetism, an explanation as satisfactory and explicit as that of the medical student in "Le Malade Imaginaire," who when asked by his examiner "why opium caused sleep?" replies, '*Quia est in eo virtus dormitiva.*" (Moliere Oeuvrez Mal. Imag. interlude.)

During the Middle Ages, when ignorance and superstition held high carnival, the most extravagant claims were set up for the effect of the magnet.

The writers of that dark era thought it capable of attracting wood or flesh. "There is now adays, a kind of *adamant* which draweth into it fleshe, and the same so strongly, that it hath power to knit and tie together two mouths of contrary persons and draw the heart of a man out of his bodie without offending

any part of him" (*Certain Secret Wonders of Nature*, by Edward Fenton, 1569); it was in their opinion capable also of both causing and curing melancholy, in proof of which we find old Burton says, "Nicholas Cabeus a Jesuit of Ferrara, in the first book of his *Magnetical Philosophy*,cap 3,speaking of the virtues of a loadstone, recites many several opinions. Some say that if it be taken in small parcels inward, *si quis per frustra voret, juventatem restituit*, it will, like viper's wine, restore one of his youth, and yet if carried about them, others will have it cause the melancholy. Let experience determine." (*Anat. of Mel.* p. 2, sec 4, 1631, ed. of 1847, p. 394). It would also act as a love Philtre and test the chastity of a woman (?)

The earliest medical use of the magnet that I have met, is that suggested by Pliny, (xxxvi 25) that it be pulverized and applied to burns. The teaching of Avicenna (980-1037) was that iron taken internally was poisonous, and as an antidote, he recommends the use of the magnet in doses of one grain—which by uniting with the iron would render it, as he thought, inert.

But previous to and for many centuries after Avicenna, its use was chiefly external, either in the shape of the unbroken loadstone or pulverized and compounded with the ingredients under the names of *Emplastrum Magneticum* (see Oribasius, 456-279, Aegineta, 514, and Aetius, 252 in *Princeps in Med. Artis*—also *Institutiones Mat. Med.* 1774, by Jas. R. Spillman p. 497). Of course the most obvious reason for its external application was its action in drawing out iron bodies from wounds. Gilbertus Anglicus, who is supposed to have flourished in the reign of Edward I, of England, about 1290,and wrote the earliest medical work, extant by an English author, under the title *Compendium Medicinæ tam Morborum universalium quam particularum*, Lugduni, 1510, says under the heading, "*De Ferro vel spino vel ligno inherente*," (*op. cit* lib. iv. c. 180) "Certain (surgeons) apply adamant or magnet, if iron is concealed in theflesh." ("*Quidam aut subligat adamantem vel magnetum si ferrum intus lateat*"). I shall give a curious illustration of this further on. For the cure of Hernia it was proposed by Kirches (1602-1680) in his work *Ars Magnesia* (1640), to administer iron filings to the patient and apply the *Emplastrum Magneticum* to the hernia externally, on the belief that the attraction of the magnet for the iron would draw in the protruding intestine and replace it, and Ambrose Parè, on the faith of a surgeon, reports cases of hernia relieved by this method (see Amb. Parè's works trans. by Johnston 1678, p. 206). Andry and Thouret, in their memoir entitled *Observationes et recherches sur l' usage de l' aimant en Medicine* (*Trans. de la Societe royale de medecine pour l' annee* 1779, tom iii, p. 53), report cases where a knife had been accidentally swallowed, and the surgeons succeeded in bringing the point of the knife to the integuments by the aid of the *emplastrum mageticum* and were thus guided to the incisions in removing it. These cases occurred in Prussia about 1635.

A case where a needle had lodged by accident in the side of the throat in a situation which deterred all surgeons, to whom the patient applied, from operating, lest more harm than good might result from the attempt, was at last relieved by the application of the loadstone, not the plaster, in the hands of a traveling mountebank, as "fools rush in where wise men fear to tread." But the description of the Quack is so graphic that I cannot forbear giving the report in the words of the narrator, as quoted for me by the kindness of Dr. Jno. S. Billings from a copy in the Surg. Gen's. Medical Library.

Acus gutturi inhaerens magnete extracta.

* * * "Dum aquis spadanis hauriendis sanitatis causa indulget Hera, Ancilla quædam imprudens acum deglutierat, quæ tali ratione infixa erat partibus internis gutturis, ut loquelam ei redderet difficilem, illa ceterum innoxia descendit ad tonsillas, atque ibi novem omnino annis hæsit manifesta, quia tactu percipiebatur, nulla tamen inflammatione infesta: puella anxia nihilominus, ne tandem in malum atrocius erumperet loco non suo positum, metallum varios sollici tat Chirurgos,manum adhiberent

excidendæ acue: nemo audet majoris mali formidine. Jam vigesimum tertium annum cum supervenit homo, ex eo genere, qui cum ætatis agebat; nihil, vel parum de Medicina medicamenta tamen aliqua nacti, quæ cum adhibita, morbus aliquos sanent, illi omnia omnibus audent promittere, et dum omnibus manum adhibent, tandum quadum inbuuntur experimentali in multis scientia: is ergo; quem dixi, homo huic nostræ accedenti facilem promittet ab ea sive molestia, sive anxietate liberationem. Illa credit: hic incipit: et cultro levi facta incisione turundula pellem nonnihil deducit, et magnetis (non pulverem, ut vulgo fit) sed frustum vulneri apponit: res mira; post nonum diem lapidi adhæret acus, et puella liberatur."

(*The Kerckringii Spicilegium Anatomicum*, Amstelodami, sumptibus Andreæ Frisii, 1670, Obs. xliv. p. 99.)

The first who mentions the topical application of the magnet in nervous diseases, was Aetius of Amida (550–600 vid. *op. cit.* in *Principes. Med. Artis* 252).

It was thus employed in gout, spasm, and especially hysteria, and in painful diseases generally. Paracelsus (*op. omnia* 1660 11. p. 175) extended its use to leucorrhœa, diarrhœas and hæmorrhages. Up to the 18th century the native magnet was thus used, but after that date, artficial magnets were employed and the Periodicals were crowded with reports of its success in nervous maladies (vid *Recherches sur l'usage de l'aimant dans les maladies nerveuses*, by M. Bolton, Hamburg, 1775, and *Le Recueil des effets salutaires de l'aiment dans les maladies*, by M. de Harsu de Geneve, 1782, and Andy & Thouret *op. cit. supra*). Though it is not pertinent to a historical paper to discuss the value of remedies, we may be allowed to say *en passant*, after a careful reading of the memoir by Andy & Thouret, that a large amount of the good effect attributed to the use of the magnet in nervous diseases, reported by them, was evidently due to the moral effect of the application to impressible subjects of a novel remedy. In such cases, with the necessary amount of faith, almost anything is a remedy—'*Possunt quia posse videntur.*'

The next use of the magnet, either native or artificial, or electric, and one in vogue to this day, was the removal of spicula of iron imbedded in the eye. The first recorded case is one by Fabricius of Hildanus (1627), and as it is so frequently referred to in the literature of the subject, I give it (thanks again to the kindness of Dr. Jno. Billings) in full.

The candor with which the old surgeon compliments his wife's suggestion, and acknowledges his own failure, is very commendable. The '*corneæ parrem*' is a clerical error, I suppose, for '*corneæ partem*'. Fabricius was practicing at this time, near Berne, Switzerland, and the "Lacus Bielomfus" was Lake Bienne, or as the Germans call it, Biel, 16 miles from Berne.

De scoria chalybis corneae infixa, ejusdemq; ingeniosissima curatione.

* * * "Rusticus quidam ex valle S. Mic, ut vocant, prope lacum Bielemfem, Benedictus Barquin nomina, cum Chalybem apud mercatorem emeret, optimum que eligere vellet; et proinde ut fieri solet, frustum contra frustum allideret, scintilla ipsi in illam corneæ parrem, ubi Iris conspicitur, prosiliit, ibidemque membranæ firmiter in hæfit,idq; non sine dolore maxima. Adstantes quum per plures dies frustra omnem adhibuissent diligentiam, dolores quinetiam atq; inflammationes mirum in modum adanctæ fuissent, venit ad me Bernam quinta Martii, Tunc prius institutâ optimâ victus ratione, etc., evacuato corpore, tam per pharmacum quam venæ sectionem (est enim Plethoricus), Primò instrumentis et quidem diversis vicibus, et per dies aliquot, tentavi, an scoriam extrahere possem, fed adeo erat exigua, ut instrumentis ilam extrahere non licuerit. Quapropter aliam viam inite, et beneficio sacculi, cujus fit mentio Cent. 4. Observ. 17, illum extrahere constitui, sed iterum oleum et operam perdidi, en uxor mea remedium longè aptissimum excogitat. Interim enim dum ego ambabus manibus, palpebra aperio, illa Magnetem oculo quam proximè æger id sufferre potuit, admovet. Id cum aliquoties, et quidem repetitis vicibus fecissimus (non diu enim lucem, quâ tamen hâc in re summopere opus fuit sufferre potuit) tandem scoria ex oculo nobis omnibus videntibus, ad lapidem prosiliit."

(*Guilhelmi Fabrici Hildani observationum et curationum chirurgicarum centuria V. Epistolis virorum doctorum, nec non instrumentis ab Autore inventis illustrata..* Francofurti apud E. Merianum, MDCXXVII, Obs. XXI p. 59.)

The next case of its use recorded, is one reported by Dr. Turberville, of Salisbury, England, which is mentioned in a letter by him to Mr. William Musgrave, dated Oct. 5, 1684, and published in the *Philosophical Transactions* (XIV, No. 164, 1684, and in the abridged edition, iii. 1683–1694). The communication is headed "Two letters from that experienced oculist, Dr. Turberville, of Salisbury, to Mr. Wm. Musgrave, S. P. S. of Oxon, containing several remarkable cases in physic, relating chiefly to the eyes." The doctor states, "A person in Salisbury had a piece of iron, or steel, stuck in the iris of the eye, which I endeavored to push out with a small spatula, but could not, but on applying a loadstone it immediately jumped out."

I am the more particular in giving the authority for this case, as Dr. S. Snell, in the *Brit. Med. Journal* (1880, ii. p. 83, and 1881 and 1882,) refers to a work of Dr. Miches, published in 1745, for a report of Dr. Turberville's case, while the *Philos. Trans.*, at Dr. Snell's elbow, where the original appeared, were not apparently consulted, and hence Dr. Turberville's name is not mentioned by either Dr. Miches (as quoted), nor by Dr. Snell. This is Hamlet with the part left out.

The next case on record of the use of the magnet in eye surgery, is that reported as occurring in his own practice, by J. B. Morgagni (1682–1771) in his work "*De Sedibas et causis morborum per anatomen indagatis*" 1761. (Lib. 1, Let. xiii., c. 21–22.) His case was one involving the cornea only, and has no special features requiring its detail. Eighty-one years elapsed before a similar use of the magnet was recorded, and this was for the removal of iron fragments from behind the iris by Dr. Meyer of Minden, in 1842: the first case on record for the removal of fragments of iron from the interior of the eye, according to the assertion of Dr. Hirschberg in his monograph "*Ueber die Magnet Extraction von Eisensplittern aus den augeninnern*" (Berlin Klin. Wochenschrift, Jan. 1883, No. 5.). He also says Dr. Myers' case is recorded in "Die Krankheiten und Missbildungen des Auges," by Karl Himly, Berlin, 1843, and in "Med. Zeitung, von verein für Heilkunde in Preussen," 1842. ii.,to neither of which works have I had access. (See also *id. ib.* 1879, No. 46, and Brit. Med. Jl., 1880, vol. i., p. 778, and review of Hirschberg's paper by J. A. Spalding in Arch. Opthal. XIV. 426.)

The next case of its use was by Dr. Alex. H. Bayly, of Cambridge, Maryland, in 1846, as reported in MARYLAND MEDICAL JOURNAL, Feb. 13, 1886. This was a case involving the cornea only, and the artificial magnet (Horse-Shoe) was successfully employed, it being the first case recorded of the kind in America, and the fifth in all medical literature, according to my present information.

In 1874 Dr. McKeown, of Belfast, next followed in the use of the magnet for the removal of iron from the vitreous chamber.—(Brit. M. J., i., p. 800, and ib., 1878.)

1878. McHardy reported similar cases in Trans. Clin. Soc., Lond. xi.

1879. Dr. Hasner, of Präg, employed the magnet for same purpose (Hirschberg *op. cit.*). In the same year Prof. Hirschberg reported his own use of the electro-magnet in such cases. (Berl. Klin. Wochenschrift, No. 46, and Brit. M. J., 1880, i., p. 776.).

1881. D. Snell reported cases (Brit. M. J., May 29, and ib. 1882.).

1884. Dr. J. J. Chisolm, of Baltimore, removed a very large fragment of iron from the vitreous by the aid of Greuning's magnetic needle, as described in Med. Record, Ap. 24, 1880, (Trans. Med. and Chir. Fac. of Md., 1884.).

The cases of the use of the magnet in eye surgery enumerated, in chronological order, are:

1, 1627. Hildanus of Berne.
2, 1684. Turberville, of Salisbury, Eng.
3, 1761. Morgagni, of Italy.
4, 1842. Meyers, of Prussia.
5, 1846. Bayly, of Maryland.
6, 1874. McKeown, of Belfast, Ireland.
7, 1878. McHardy, of London.
8, 1879. Hasner, of Präg, and Hirschberg, of Berlin; since which time the use of the magnet in some form, in such

cases, has been recognized as an established procedure.

Society Reports.

BALTIMORE ACADEMY OF MEDICINE.

STATED MEETING HELD MARCH 16, 1886.

MYOPIA WITH INTENSE SQUINT.

Dr. J. J. Chisolm said that myopia, with intense squint was very rare, the reverse being the rule. He has, however, lately had a case with a most pronounced convergent strabismus and a high degree of myopia. He operated three times in the usual way, and was finally obliged to not only do a tenotomy on the internal rectus muscles, but in addition to stitch the ball to the outer angle of the eye in order to keep it in its straightened position. By this procedure one eye was straightened, but the other still has some squint left. The myopia was congenital, and the high degree of squint was brought about by the very short range of vision.

PEDUNCULATED GROWTH OF THE LABIUM.

Dr. H. P. C. Wilson showed a pedunculated growth, of about the size of a hazel nut, that he had removed from the labium of a young woman. He takes it to be one of the common moles. He removed it because it gave rise to considerable irritation when she walked. It grew from the skin surface of the labium.

Dr. J. Edwin Michael referred to a case he had reported some time since of a similar growth of about the size of two fists that grew from the left labium majus. It was attached by a pedicle of about the size of the thumb. When in the recumbent posture the growth lay close up between the thighs but when standing its elasticity permitted such stretching that by its own weight it hung down almost to the knees. He removed it and recovery took place without any accident. When he first saw it, it was sloughing at its lower part, probably from a bruise. He has always been at a loss to understand how the woman had become pregnant, with a growth of such a size in such a position.

Dr. Hiram Woods read a paper on

FOREIGN BODIES IN THE ORBIT,*

and related a case in his own practice.

DISCUSSION.

Dr. J. E. Michael has never, in his experience, seen an orbit that he thought could accommodate a piece of wood 3.3 inches long without one end sticking out.

Dr. Woods is unable to find a skull in which the orbit exceeds two inches from before backward. He read the original report of the case referred to, as quoted by Lawson in his book on "Injuries to the Eye Orbit and Lids."

Dr. J. J. Chisolm some years since treated a man who had been stabbed with a penknife through the upper eyelid into the orbit; the lid wound healed kindly, but the orbit wound began to give trouble; he removed later from the socket tissues a piece of knife blade over an inch long. No injury to the ball.

Dr. W. C. Van Bibber had seen some years since a case of tetanus in a man who had the disease as a result of a foreign body in his foot. He had fallen upon it from a distance, and the metal had become imbedded in the tissues. The size was so great that he preferred not to estimate it then, as he did not have the foreign body at the meeting with which to corroborate his statement.

Dr. P. C. Williams saw in one of the Paris hospitals a man who had been shot under the right eye, and the ball came out behind the left ear. He recovered.

Dr. J. J. Chisolm has seen these injuries destroy both sight and hearing, without destroying the brain. He had once removed a splinter of hard wood from a man's cheek. It had remained in this position, just below the eye, for nine

*See page 459.

years, without giving rise to any trouble whatever.

Dr. Chas. H. Ohr had seen a man in whose flank a ball had entered, splintering the spinous process, and coming out behind the hip joint on the opposite side.

Dr. J. E. Michael has no doubt of what *has* happened; but certainly, lately—that is, in the last four or five years—all the gunshot wounds that he has seen, if fired from a pistol of any size, were remarkable for the *direct* course taken by the ball. It may be due to an improvement in the kind of firearms now in use, or in the ammunition, but certainly in his cases the ball has passed straight through all the tissues.

He cited the Garfield case as a result of what may be done with the 38-calibre English bull-dog pistol, the weapon most commonly used.

Dr. C. H. Ohr thinks deflected bullets are usually partly spent, or else are feebly propelled. He does not believe a ball will usually be deflected, if properly propelled and fired at close range.

He had seen a case of a man who held a pistol in his hand, and directed it into his thigh, just above the internal condyle of the femur; the ball passed straight through the joint and came out below the head of the fibula.

Dr. P. C. Williams thinks the angle at which a ball strikes a tissue has much to do with the direction it takes afterward.

Dr. J. J. Chisolm thinks short range will explain the frequency of straight wounds in civil practice.

Dr. J. E. Michael had recently seen a man who had, in attempting suicide, fired four small balls (22 calibre) into his head; none of them penetrated the skull.

Dr. B. B. Browne read paper on

TRAUMATIC ATRESIA OF THE CERVIX UTERI WITH TWO CASES.

Obliteration of the cervical canal is due to various causes, the most frequent cause of traumatic atresia being long and difficult labors accompanied by laceration and followed by suppuration and gangrene. Formerly when strong caustics were used more freely than at present constriction and complete obliteration, either of the cervix, or the upper part of the vagina behind which the cervix became enclosed, frequently occurred. In the two cases which I relate the condition was caused by difficult and prolonged labor followed by a protracted recovery.

Mary G., age 27, 13 years married, was delivered of twins 12 years ago. She was in labor three days and had puerperal fever afterwards and was an invalid for nearly one year. Her menses had not appeared but she suffered with intense periodic headaches, and at times severe convulsions.

Upon examination the vagina ended in a cul-de-sac about two inches deep, which seemed to be separated from the uterus which could be felt about one inch above. The uterus could also be clearly outlined by rectal examination.

The end of the cul-de-sac was opened in a line corresponding to the line of cicatricial union, and the cervix separated and dilated. A Gland glass tube was inserted into the cervical canal and a larger one in the vagina. It is a remarkable circumstance in connection with the history of atresia or absence of vagina, even when no uterus can be found, or only a rudimentary one incapable of performing its functions, that the artificial formation of a vagina brings considerable relief.

Mrs. Elizabeth W., of small size, aged 27, married three years, one child eighteen months ago, labor said to be very difficult and accomplished after craniotomy; had a long and protracted recovery. Has not menstruated since, although has had the menstrual molimen.

Examination revealed a stellate laceration of the cervix and complete atresia of the uterus. The uterus was considerably enlarged.

Operation January 6. The canal which consisted of cicatricial tissue about one half inch in thickness, was opened and about one half a pint of thick grumous blood was discharged, the cavity was then thoroughly washed out with hot carbolized water and the curette was

also used to remove clots of the grumous mass which were adherent to the walls of the uterus.

One month later first menstruation came on normally and lasted three days.

In reviewing the history of these two cases it was evident that the atresia was the result of ulceration and sloughing following difficult instrumental delivery. In neither case was any treatment used to arrest the imflammatory process. The importance of thorough antiseptic vaginal irrigation in all such case where the lochial discharges become muco-purulent and fetid cannot be over estimated.

DISCUSSION.

Dr. H. P. C. Wilson thinks the cessation of menstruation in apparently hearty women without any visible cause, very singular. He has seen more women cease menstruating between 20 and 30 years of age than between 30 and 40.

Saw one woman æt. 21, a picture of health, in whom the menstrual function suddenly ceased. No cause whatever could be found.

Dr. B. B. Browne said, as to the opposite courses taken by his two cases after operation, he thought it could be explained by the fact that in the case in which menstruation was not re-established, that the atresia had existed for twelve years, while in the one in which the function was restored the atresia had only been present for eighteen months.

Dr. J. Edwin Michael reported a case of

ANTISEPTIC AMPUTATION OF THE BREAST.

Mulatto woman, æt. 38 years, weighs 235 pounds, mother of ten children. Her breasts were in size proportionate to her weight. The growth was to the median side of the mamma; no axillary involvement. When the operation was finished the wound measured nine inches in length. Wire sutures were used; drainage tube laid in the wound throughout its whole length, and protruded from the most dependent angle.

Iodoform and oakum constituted the dressing.

The wound was opened for the first time on the ninth day, and everything was found to have healed; the tube had slipped into the wound, and had to be dug out. There was no pus formation. At present the woman is apparently well.

Antiseptic precautions were strictly observed throughout the whole operation.

Dr. H. P. C. Wilson was strongly in favor of antiseptic precautions in all surgical procedures.

Dr. P. C. Williams has had union by first intention, and complete healing of the wound by the ninth day in his breast amputations, and he has never yet used antiseptics, nor drainage tube.

Dr. J. E. Michael has also had good results without the use of antiseptics, but thinks as a rule we are safer in using them.

Dr. H. P. C. Wilson is satisfied that in this particular case where such a very large wound was necessary, had Dr. Michael avoided antiseptic precautions his result would not have been so good.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD MARCH 8, 1886.

The President, Dr. W. F. A. Kemp, in the chair, J. M. Hundley, M.D., Secretary.

HYDROPHOBIA.

Dr. A. Atkinson read a paper on hydrophobia, and said the attention now given to the disease would lead one to believe that it was of more frequent occurrence than formerly. The disease is generally well marked in man and in the lower animals, being characterized by great nervous excitement, by the secretion of an uniformally viscid saliva and often a great dread of swallowing, whether of liquid or solids, and is almost sure to end fatally. It is caused by inoculation from the bite of some rabid animal. Public opinion is much at fault as to some points about the disease; as to its mode of develope-

ment, its course, the season of its greatest prevalence, the time of its incubation and the signs by which it may be recognized. We cannot say it never arises spontaneously, though nearly all evidences point adversely to such an origin. We find the disease in nearly all animals —chiefly, however, in the canine or feline species. Carniverous animals are most prone to attacks. Herbiverous ones less so, though if inoculated manifest the disease in like form and severity as the carniverous.

The Period of Incubation. — We have in most infectious diseases what is termed the period of incubation. Jaccauld collected 214 cases of hydrophobia and found the period of incubation was less than one month in one-fourth the cases; from one to three months in 143 cases; from three to six months in 30 cases and from six to twelve months in 11. Gourgie gives it in the majority of cases as from four to eight weeks.

Dr. Elliottson saw six cases of the disease and estimated the time of incubation to vary from six to sixteen weeks in the dog as well as in man. He cites the case of a pack of hounds in Yorkshire, England, which were bitten by a rabid dog, the disease appearing at intervals of from six to sixteen weeks as stated. Dr. Bordsley gives the case of a shepherd whose hand was merely licked by a dog and who had the disease within the aforesaid time. The child of Edward Applegath, of Spottswood, N. J. died of the disease in January, 1886, just 21 days after being bitten. *Per contra* a man named Faust, in Akron, Ohio, recently struck another in the month, wounding his knuckles on the teeth. The part became greatly swollen and the man died from blood poison, raving like a mad man for ten days. In 1867 a child died in this city fourteen days after being bitten by a rabid dog. The dog died two days after inflicting the bite. Dr. Atkinson said he saw a case in a man age 46 years. He was bitten on the shin by a fierce dog. The dog was eating and the children were worrying it. The father seeing the dog snap at the children kicked it, the dog biting him as stated. The wound did not heal entirely, but caused no trouble for six weeks, when the man was suddenly seized with a sense of great depression and died in twelve hours. The characteric features of the case were the extreme depression, the horrible dread of death and the indisposition (not inability) to swallow anything. The dog was allowed to live and showed no signs of rabies.

Cause.—In man we know the disease is produced by the virus of some animal rabid for the time, or permanently so, and yet there are a few cases which rather favor its possible spontaneous origin. Heat, anger, bad or insufficient food are said to favor the production of the disease in the dog. Certain it is, that in man the fear of a disease will act as a great depressant on the nervous system, rendering the individual especially susceptible to the disease he may dread.

Time of the Year for Hydrophobia.— For a great while it was thought that more cases occurred in the heated terms of summer, the so-called days of August, but Bonley collected 3,000 cases, of which 27 per cent. occurred the in spring months. Professor Key, of the veterinary school at Lyons, has observed that the number of rabid dogs in that section was greater in early spring.

Effects of the Bite.—The effects of the bite of a rabid animal are by no means commensurate with the size or condition of the bitten part; indeed the wound is mostly slight, healing up rapidly and giving little or no pain, the great risk not being from the severity of the injury, but from the absorption of the saliva which contains some very active poison which is capable of being quickly absorbed. Some circumstances may modify the absorption and the activity of this poison; indeed it has been supposed that man is very decidedly less susceptible to its influence than is the dog and Mons. Renault, at the Alfort school for experiment on animals, near Paris, found that dogs bitten by rabid animals *did not go* mad in the rate of over 33 per cent. of those bitten, say one-third; again the thickness of the clothes may modify the entrance of the saliva into the skin or it may not come in contact with a raw surface, or

the saliva may be washed away by the excessive flow of blood, if the wound is a large or in a vascular part, or the virus may be destroyed by the agency of chemical or surgical means. Certain it is that all bites from rabid animals do not produce hydrophobia; perhaps, three in sixty bitten have the disease.

Nature of Hydrophobia. — Marachette, a Russian physician, thought the virus was contained in small vesicles under the tongue; these vesicles usually appear from the third to ninth day. As far as known rabies is readily transmitted from the bite of the rabid animal, the teeth making two or more abrasions or holes and the saliva being conveyed both on the moistened tooth and by the moisture of the mouth; that is, inoculation from the rabid animal seems to be instantaneous. There seems to be in the dog a disease called "Dumb Rabies" which has been mistaken for the genuine affection. It was so called because the animal is unable to give utterance to its troubles and because it either cannot or does not bite. It holds its mouth half open, being unable to close its jaws so as to seize objects. The animal seems greatly anxious until it becomes unconscious and generally the end is death, though cases do recover when left alone. These pseudo-cases take on very much the aspect of *epileptoid* convulsions, as well as the affection seen in the horse and called "*Blind Staggers*" (no doubt cerebro-spinal meningitis) in which the horse like the dog shows a disposition to bear to the left, whether in walking or staggering. The bacillus of rabies has never been isolated.

Appearance of the Bitten Parts.— The wound may present no special difference from a bite by a non-rabid dog, but now and then there will be redness, dryness, numbness or a sense of itching in the part, when the case is to develope into the disease we are studying, no matter whether the bite be still open or a fully healed cicatrix. The healed wound may become swollen and with red cords or lines, one or many, beginning at some point in the wound and running up the limb to the nearest lymphatic gland—a subacute lymphadenitis so to speak. This may last for two to four days and yet the patient be only feverish and uncomfortable. Soon the more alarming signs may succeed with greater or less rapidity.

Signs in the Dog.—Youatt and Bonley claim that the first signs in the dog going mad, consist in a gloomy disposition with a nervous agitation and disquitude, which are betrayed by frequent change of position. The dog usually cheerful and fond of companionship, seeks to avoid his master, skulking away into its kennel, into a closet, under furniture, trying in every away to escape notice; if called out he obeys slowly, but again returns to his covert. He soon appears dissatified and changes his position, often wandering from place to place. Yet dogs will demean themselves in this way when they are uncomfortable, as with wounds, fever or indigestion, as well as in the beginning of distemper. The main points are that the animal *seeks to avoid* observation and that he is never still for any length of time. These two traits go far to attract attention when taken together and should become at once objects of suspicion. Later on he may have hallucinations, seeming to hear sounds, and stares and snaps at imaginary objects; at this stage of the disease he may not show any disposition to bite his master and yet will be easily provoked at a stranger; during this period the animal has no dread of liquor, but after the disease shall have become more fully developed, deglutition becomes difficult and painful because of constriction of the muscles of the throat. This supposed dread of water is a fatal mistake, as many a dog may be rabid, and yet partake of water even if he has to thrust his nose deep down in the water to cool his mouth and enable him to drink—nor does the dog at first refuse to take his food. The bark now becomes peculiar, more of a howl, which is hoarse and muffled. The saliva now becomes apparent around the mouth, and is very viscid and tenacious, and small in quantity. Clonic convulsions are usually present at some stage of hydrophobia.

Point of Election.—We cannot say

positively that there is any centre or point of election for the virus to act on in producing this affection, but many symptoms lead us to believe that it is the centre of respiration in the medulla oblongata.

Duration.—It is a very acute disease; the first stage lasts from one to three days, the average time being twenty-four hours, while the second stage may last as long, or end in a few hours.

Symptoms.—They usually declare themselves, if at all, in *twelve weeks.* The chief signs in man is a sharp pain in or about the wound, headache, an excitation of the intellectual faculties and of the organs of sense; more or less disorder of the digestion and more or less difficulty in swallowing, or a sense of constriction of the entire throat, attended by a burning and unappeasable thirst. Now begins stiffness of the muscles of the neck, around the jaw; increased anxiety and depression, often attended by hallucinations and delirium. Thirst now becomes great, and swallowing so difficult that the patient fails to convey the fluid to the stomach, the muscles expelling it from the mouth. This dysphagia has given rise to the idea that the patient is afraid of water, while he is always dying from thirst.

The Prognosis may be said to be always unfavorable, the patient nearly always dying in great suffering.

Mode of Death.—Death is apt to follow from suffocation and difficulty of deglutition, or from great nervous prostration, the disease generally lasting from three to six days. The viscid saliva causes great worry, which with the convulsions reduce the patient's strength to the last extremity.

Pathology.—Of the pathological changes in this affection, but little is known, except perhaps a general state of congestion of the brain and spinal cord. Dr. Ross found the grey substance of the spinal cord infiltrated with leucocytes.

Prophylaxis.—The idea of preventing hydrophobia is upwards of a hundred years old. Absolute prevention will be freighted with incalculable benefit to the human race, if it should prove possible, as at last seems likely through the untiring efforts of Pasteur and his coworkers. If a bite from a rabid animal be received, it should be cauterized *at once*, thereby coagulating the fluids around and occluding the absorbents and capillary vessels. It is a good plan to wash the wound and apply strong cups to induce a full flow of blood. The heated iron, stick nitrate of silver and caustic potash are about the best agents with which to cauterize the wound. The liquid caustics are not so good, for the reason they cannot be made to penetrate to every part of the wound.

Treatment.—Very many agents have been at different times lauded as cures for this fearful disease, but with few exceptions they have all left the patient to die. Turkish baths, elecampane root, camphor, opium, calabar bean, physostigma, chloroform, chloral, &c., have all been used, and with but little success. Of course all have heard of the wonderful effects of the *mad stone.* The medical profession as a rule have no confidence in its virtue.

DISCUSSION.

Dr. J. W. Chambers said he had never had a case of hydrophobia, nor had he ever seen anyone that had, though he had made repeated enquiries. The strange part of the disease to him was the long incubation period, which may vary from a few days to twelve or thirteen years. Why it remained so long dormant in the system he could not imagine; it was certainly contrary to reason and common sense, and unlike anything in that respect he had ever seen. He thought many of the cases reported as hydrophobia were nothing more than tetanus, or some other nervous affection.

Dr. Geo. H. Rohé asked Dr. Chambers if he referred to hydrophobia in animals or man.

Dr. J. W. Chambers said in man.

Dr. Geo. H. Rohé, in answer to Dr. Chambers, as to the incubation period of hydrophobia, said the doctor certainly saw in syphilis a very variable period.

Dr. J. T. Smith said that Pasteur made two divisions of hydrophobia: 1. The acute, when it developed in a few days. 2. When it comes on late, it is

akin to hysteria, and may be properly called *lyssophobia*. Hydrophobia is as easy of explanation as hysteria.

Dr. Geo. H. Rohé said Pasteur three years ago announced that he had isolated the *organism* peculiar to hydrophobia, but afterwards retracted the assertion after finding the same organism in healthy man. In such a case Dr. Chambers could certainly not accuse him of insincerity. Dr. Rohé said that such a disease as hydrophobia could not be questioned, if any one would take the trouble to read what Dr. Law had written on the subject. He had never seen a case, but knew a gentleman that had had one (Dr. Holt), and he was a man of intelligence and truth. In his case the incubation period was short. The doctor said he well remembered the time when elecampane root was much lauded by the daily papers, and freely used in the cases occurring in Western Pennsylvania. As to the giving of camphor in fifteen or twenty grain doses, as indicated by Dr. Atkinson, he would be afraid of such doses.

Dr. E. G. Waters said he had never seen a case, but knew of several. One was under the care of Dr. N. R. Smith; the same dog that inflicted the wound in this case, also bit a little child on the cheek, which bled freely. The child did not have hydrophobia, but the man had it and died. The treatment pursued in the case by Dr. Smith was the vapor bath; as soon as the steam began to condense and run down the body, the man became wild, and in the paroxysm he ran into an adjoining room, jumped into the bed and died. The second case was treated by Dr. Krozer, of this city, and it died. The doctor quoted Dr. Watson as saying that idiots and small children have been known to have hydrophobia. Such facts strongly preclude the idea that the disease is a myth. Stronger proof still is, that all so affected die. He cited the case of a pack of hounds owned by Lord Fitzwilliams. They were bitten on the night of June 8, 1791. Six of them subsequently went mad—in 23 56, 67, 88, 155 and 183 days respectively—and all died.

Dr. W. F. A. Kemp said he had known of four cases, two of which he saw just before death. The peculiar expression of their faces and eyes he had never been able to erase from his memory. In no disease had he ever seen such expression, and believes them to have been true hydrophobia.

Dr. A. Atkinson said the case he had died in twelve hours. The man had spasm of the muscles of deglutition, but could manage to swallow, and also had the horrible facial expression alluded to by the speakers.

Dr. H. H. Biedler had seen a case in a cow, which was produced by the bite of a rabid dog. The cow was killed after a few days of great nervous excitement and suffering.

Dr. S. M. Free wished to know if hydrophobic saliva be swallowed, would it likely produce the disease?

Dr. E. G. Waters said that Dr. Watson believed there must be an abrasion of the skin or mucous membrane to allow absorption of the virus.

Dr. J. L. Ingle asked if the incubation period could extend from a few days to ten or fifteen years, how can Pasteur say with certainty his patients after inoculation are exempt and will escape the disease till the full limit of time has expired?

Dr. Rohé said that Pasteur in inoculating his patients shortened the period of incubation, just as is done in the inoculation for the prevention of smallpox.

Dr. E. G. Waters said, it is claimed that the bite of a rabid wild animal produces more certainly hydrophobia than the bite of a rabid dog.

Dr. J. W. Chambers said he believed that there was such a disease as hydrophobia, but did not credit the long incubation period of twelve years.

Dr. Ingle said that men eminent in the profession say, it is *claimed* to appear after twelve years of latency.

Dr. Rohé said they may mention that it is claimed, but they do not assert that such is a fact.

Professor Da Costa alleges that he has seen marked improvement in posterior spinal sclerosis from the long continued use of the following formula. ℞ Hydrarg. bichlor. gr. ss, ammonii chlorid. gr. xl, aquæ ʒii. M. One teaspoonful one hour after meals.

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BALTIMORE, APRIL 10, 1886.

Editorial.

ON THE STOMACH OPERATIONS PERFORMED AT BILLROTH'S CLINIC FROM 1880, TO MARCH, 1885.—We are receipt of a monograph by Dr. Victor Ritter von Hacker, giving a detailed account of all the operations which have been performed upon the stomach, by Prof. Billroth and his assistants during a period of five years. He divides the cases into the following heads. 1st. Gastrotomy, for the removal of foreign bodies. 2nd. Gastrorrhaphy, for wounds or rupture of the stomach. 3rd. Gastrostomy, or the formation of a fistula for the introduction of food. 4th. Gastrectomy, or the incision of some portion of the stomach in its continuity. 5th. Gastroenterostomy, or the formation of an artificial communication between the stomach and small intestine. In the first category is related but one case, that of a girl who swallowed her false teeth, for which gastrotomy was successfully performed; the patient leaving the institute in five weeks. Gastrorrhaphy was performed twice, once for rupture of the stomach, and once for gunshot wound; both ended fatally, one in four and the other in twenty-eight hours. Gastrostomy was performed four times, with one temporary recovery. Of these cases, one suffered from a cicatricial contraction of the œsophagus due to swallowing of caustic soda; the others were on account of cancer. In two cases the operation was performed in stages, the stomach being first attached to the abdominal wound and after the lapse of several days opened. In the last two cases the operation was completed at one time, which procedure allows the immediate introduction of food, thereby conserving the strength of the patient without apparently increasing the dangers of the operation. In regard to the non-malignant strictures of the œsophagus which are permeable for fine filiform bougies, von Hacker makes a suggestion which, as far as our knowledge extends, is original and is worthy of special notice; which has moreover the merit of having proved successful in his own hands. He recommends the introduction of a whalebone filiform to the upper end of which a fine drainage tube is attached, and whilst the tube is drawn out into a fine strand, the guide is seized from below and is pulled out through the gastric fistula, and the elastic cord is thus made to pass through the stricture, and is thus allowed to recoil, and by its increase in size constant elastic pressure is exerted upon the obstruction, which gradually becomes absorbed until larger instruments can be introduced. Gastrectomy or resection of the pylorus has been performed by Billroth and his assistant Welfler eighteen times, with eight recoveries or 44½ per cent. and ten deaths or 55½ per cent. Most of these have been previously reported and may be found tabulated in Dr. Randolph Winslow's statistics in the *Amer. Journal of the Medical Sciences* for April, 1885, but four additional cases, all fatal, are now published for the first time. These cases give the percentage of recoveries in Billroth's hands as 43¾ instead of 54½, which was the proportion deduced from the previously reported cases. The indications for operation were cancer in fifteen cases and cicatricial stenosis in three. Of the former seven recovered and eight died, whilst of the latter one recovered and is radically cured, and two died. Of those who survived the operation for carcinoma two died in four, one in nine, one in ten and one twelve months of recurrence, whilst one case was alive and well over four years after the operation, and one had

survived two years. These two cases permit a slight hope to be entertained in regard to the beneficence of the operation, but the loss of life as the result of pylorectomy is appalling, for in the hands of the most skillful and experienced operator in the world, the immediate mortality is 56¼ per cent., and from Dr. Winslow's analysis of sixty cases in the hands of many operators 73⅓ per cent. resulted fatally. From these facts it is apparent that pylorectomy does not offer more than a gleam of hope to the wretched sufferer from pyloric cancer, and unless a less dangerous procedure can be substituted the disease had better be allowed to take its natural course in the vast majority of cases. For cicatricial stenosis the matter is somewhat different, for if the patient survives the perils of the operation, he will be radically cured. Gastroenterostomy, or the formation of a gastro-intestinal fistula, has been performed at the clinic eight times, with five deaths and three temporary recoveries. This operation was devised by Dr. Woelfler as a substitute for resection in those cases in which pyloric stenosis was present, and which from one or another cause did not admit of pylorectomy, and it only aims to prolong life by allowing a resumption of the functions of digestion. In our opinion this operation should be practised at an earlier date than is customary, and should with but few exceptions supersede the removal of the pylorus.

The experience of American surgeons in gastric surgery has been anything but encouraging; removal of some portion of the stomach has been performed six times with an invariably fatal result, the opetors having been Köhler, of Louisville; Richter, of San Francisco; Winslow, of Baltimore; Connor, of Cincinnati; Spear, of Cumberland, Md., and Sands of New York. Gastroenterostomy has been performed by Ransohof, of Cincinnati, and digital divulsion of the pylorus in two cases, by McBurney, of New York, all with a fatal termination. Fortunately for the credit of our art some cases of gastrostomy have had a successful issue. In Great Britain, the results of pylorectomy have been equally as unfortunate, but a recent case of gastroenterostomy was crowned with success.

Miscellany.

EARLY AND LATE PIE-TY.

AN ÆTIOLOGICAL STUDY OF 125 CASES.

(*Respectfully dedicated to* "The Diaphragm.")

"God bless the man who first invented sleep,"
Quoth Sancho Panza, with half-opened eye;
And *pardon* him—I add—who did not keep
The fatal secret of the new-born pie!

Not that the pie hath done me grievous wrong,
Or that I malice bear 'gainst pies—*per se:*
'Tis their ubiquity, bewails my song,
Perennial dish at breakfast, dinner, tea!

Some may, perchance, decry this sweeping tone;
I point thee friend, to Holmes' biography:
"EACH MORN, the philosophic Emerson
Restored *his* protoplasmic waste—with pie."

Can he have known some dietetic law
In food's metabolistic rôle,
Whereby—O fie!—a pie may reappear
As transcendental thought and "over-soul?"

No! 'tis not here we find the mystic clue:—
I'll venture on the true solution later.
Let us descend from skies, ethereal blue,
And, in the kitchen seek its *raison d'être.*

What's in a pie? Shakspearian thought!
"Paste—*something* in or under it" (see Webster.)
Ah! 'tis a fellow of the communistic sort,
An *omnium gatherum ab extra!*

Never can larder so deserted be
When pressing haste some social duty brings,
But what thy floury mantle e'en like charity
Will gracefully enfold a host of things.

For-bear to course the various KINGDOMS through,
Past lemon, custard, pumpkin, pigeon, quince—
When Flora, Fauna—yea, and Spirit too,
Their quota yield to fabricate "ye mince."

Within the pie there lurks this subtle snare:
Its further trend I leave you to conjecture;
'Twill give to *better* desserts a deserted air
Because more handy in its architecture.

Like other *pockets*—say, in pristine pants,
How seldom will you have them empty!
'Though, if their contents met the public glance
Some odds and ends would rarely tempt thee.

March 5, 1886. P. AENEAS.

The Pathology of Arterio-capillary Fibroid Kidney.—Next to or even equal with the pulmonary functions, the renal functions stand foremost for the maintenance of health. If the former represents aërial respiration, the latter represents aquatic respiration. The one clears the system of gaseous, the other of solid excreta. The function of water in the body is probably not yet as much considered as it deserves to be, and our practical ideas of the circulation are too much restricted to the onward current through the capillary vessels, whilst the interstitial circulation, the transit of the blood plasma and water through the textures of the organs, is too often ignored.

Sir William Gull points out, in the April number of *The American Journal of the Medical Sciences*, that it is in the course of this interstitial circulation through the arteriole and capillary walls, that the first difficulty occurs which leads on to arterio-capillary fibroid changes, whether in the kidney or elsewhere. These changes are characteristic of a wide-spread pathology of the vascular system supervening about the middle and later periods of life.

Whilst we can no longer, in one large class of cases, refer the arterio-capillary changes in the various organs, including the kidney itself, to the kidney as the primary seat of disease, and to the consequent uræmia, it is still a question how far a local fibroid change beginning in the kidney, and having its origin there, may lead to systemic arterio-capillary changes of the same character as those which come on idiopathically in later life.

The Treatment of Intestinal Obstruction by Laparotomy.—Dr. Randolph Winslow reports, in the April number of *The American Journal of the Medical Sciences*, a case of acute intestinal obstruction successfully treated by laparotomy. In commenting on the treatment Dr. Winslow expresses his opinion decidedly against any and all severe methods of attempting to overcome the obstruction whether by rough manipulations, or by rectal injections under strong pressure. On the other hand, he deprecates resorting to operation until a fair trial of medical means has failed to relieve the condition, and until it is reasonably certain that there is some mechanical hindrance to the passage of the feces, which will terminate fatally unless relieved by operation. For obstruction in the large intestine, colotomy would in many cases afford relief. For persistent obstruction of the small intestine, his preference is decidedly in favor of laparotomy in the linea alba below the umbilicus, under rigid antiseptic precautions, as being the most precise, scientific, and rational means of discovering the cause and seat of trouble, and of remedying it at the same time. Whilst not underrating the risks of laparotomy, he does not think an exploratory incision to be a more serious procedure than abdominal taxis, or enemata under heavy pressure, and he thinks it much more certain and reliable in its results.

Colchicine.—A valuable contribution to the study of toxicology has been made by M. Houdé, and may be consulted in the *Répertoire de Pharmacie*, No. 1, 1886. The chemical characteristics of crystallised colchicine and its clear differentiation by the aid of certain reactions have enabled M. Houdé, by means of experimental methods, to discover the poison everywhere in the tissues and liquids of the economy. He has thus been able to draw up a scale showing the directions in which the poison is eliminated. In this scale the stomach and intestines amongst the solid tissues hold the first place, and amongst the fluids the diarrhœal stools, the urine, and the saliva (dog). The poison has not been detected by chemical research in the tissue of the heart, but the experimental symptoms—much more delicate tests—have clearly shown its presence, though in relatively minute quantity. Chemical and physiological investigations of the circulating blood have proved the absence of the poison from this fluid. Finally, the substance of the muscles, notably of those that surround the articulations and the tissues of the joints themselves, including the osseous substance, contain, as proved both chemi-

cally and physiologically, a notable proportion of the toxic agent. This last fact possesses an interest altogether apart from questions of a toxicological or forensic nature, having a far more important bearing on the mode of action of colchicine in therapeutics.—*Lancet.*

Right-sided Endocarditis.—Dr. Byrom Bramwell records, in the April number of *American Journal of the Medical Sciences*, his experince with regard to the frequency of right-sided endocarditis.

He finds (1) that right-sided endocarditis is much more frequent than is usually supposed; and that this conclusion is in no way contradicted, but on the contrary rather confirmed, by clinical evidence and clinical facts.

(2) That Sibson's arguments against the tricuspid murmur of early acute rheumatism being indicative of right-sided endocarditis, are not valid.

(3) That a tricuspid murmur occurring in the early stages of acute rheumatism in a previously healthy person who is not anæmic, is indicative of a rheumatic affection of the right heart.

(4) That whether (*a*) the tricuspid regurgitation is the *direct* result of the inflammation of the tricuspid valve, or whether (*b*) it is due to a rheumatic affection of the wall of the right ventricle, with resulting relative or muscular incompetence, the pathological evidence seems to show that when the right heart is so affected in acute rheumatism as to produce a tricuspid leakage, inflammation of the endocardium of the right heart is often (usually ?) present.

(5) That although right-sided endocarditis is of frequent occurrence, it is comparatively seldom followed by permanent organic disease of the tricuspid valve; in short, that right-sided endocarditis is an eminently curable affection.

The importance of this conclusion, if it be correct, can hardly be over-estimated. It is not a conclusion of mere scientific and pathological interest, but is of the greatest practical and therapeutic value. It shows the immense importance of rest in the treatment of endocarditis. The only reasonable explanation of the fact that mitral endocarditis is more severe and more frequently terminates in permanent vavular disease than triscuspid endocarditis, seems to be that the closure of the mitral segments is more forcible and that inflamed mitral segments are subjected to greater strain than the tricuspid segments. In treating cases of mitral endocarditis our main objects should be to imitate nature's method of cure; to place the mitral valve, so far as we are able to do so, in the same condition as the tricuspid valve; in other words, to reduce the force (and also the frequency) of the cardiac contractions and to allow the products of inflammation to be absorbed just as they are usually absorbed on the right side of the heart.

Malthus's Law and Tumor-Growth.—Mr. Jonathan Hutchinson says, in the *Brit. Med. Jour.*, (March 20th, 1886,) Malthus's law of population-increase by geometrical progression applies to the growth of tumors. The larger they have become, the more rapid is their rate of progress. It is a process of cell-multiplication; and the more numerous the cells, the greater the result of their doubling. It is important to remember this law, since it may help us: first, in prognosis; seconly, in emphasising the importance of early treatment; and, thirdly, as showing the occasional advantage of methods of treatment which diminish bulk and retard growth, although there may be no hope of cure.

The Malthusian law is often remarkably illustrated in cases of rodent ulcer, which advance very slowly at first, and very rapidly later on.

Antipyrin as a Hæmostatic.—Antipyrin, which has been largely used in the treatment of fever for reducing temperature, has proved valuable in the hands of an Italian surgeon, Dr. Casati, as a local hæmostatic. In a case of epistaxis it was employed as a 5 per cent. solution; also, after an operation, hæmorrhage was arrested in three minutes by the application of a 4 per cent. solution of antipyrin. Dr. Casiti considers antipyrin preferable to perchloride of iron or

the actual cautery for arresting hæmorrhage, because it leaves the wound quite clean, and without any eschar. It has, too, the advantage over ergotine of being non-poisonous, even in large doses, and its antipyretic and antiseptic properties are themselves in many cases of considerable advantage.—*Lancet.*

The Incubation Period of Small-pox.—Prof. Eichhorst, of Zurich, has had an opportunity of accurately observing the incubation periods in three cases of small-pox occurring in a medical man and two medical students. They were very nearly alike, and much shorter than is commonly supposed, being respectively nine day eight hours, nine day eight hours, and nine days fourteen hours; whereas it is usually stated to be from twelve to fourteen days.—*Lancet* March 13, 1886.

What Chicago is Doing for the Profession.—Homœopathy seems to be thriving at the stronghold of the Old Code. In the last six weeks two regular colleges have graduated 243 students, while two homœopathic medical colleges graduated 167. There is another regular college to be heard from which generally graduates about forty, and an eclectic college which graduates about fifty. The total annual output of regulars, therefore, is about 285, and of irregulars about 215. Of the 641 eclectic and homœopathic graduates in 1884, over two-thirds (476) were graduated from Western and Southern colleges.—*Med. Record.*

Notice of Removal.—Dr. T. Gaillard Thomas has removed from 294 5th Ave., N. Y. to 600 Madison Ave., between 57th and 58th Sts.

Medical Items.

It is stated that 65,563 persons have died in Paris during the last five years from phthisis alone.

The annual meeting of the American Surgical Association will be held in Washington, D. C., on April 28, 29, 30 and May 1st.

The third annual meeting of the American Climatological Association will be held in Philadelphia, on May 10th and 11th.

The thirty-first annual meeting of the Kentucky State Medical Society will be held at Winchester, Ky., on June 23, 24 and 25.

Dr. Jackson Piper, of Towson, Md., has been elected president of the Maryland State Board of Health, to succeed the late Professor Richard McSherry. Dr. Piper is a well-recognized authority on sanitation and he brings to the discharge of his duties as president a large experience and earnestness in sanitary work.

Sarrazin reports on five cases of hydrocele that he has has treated by injection of a solution of corrosive sublimate of the strength of 1 in 1000. The advantages are the harmlessness of the solution, and the circumstance that suppuration is never excited, a simple form of adhesive inflammation being provoked. All the five cases were completely successful.

Dr. H. M. Biggs, of New York, an expert on bacteriology, has stated that a wound or injury produced by the teeth of a non-rabid dog, one the saliva of which does not contain the living organism, whatever may be its nature, which is its essential cause, can no more bring about the specific disease known as rabies than can the wound made by a sterilized knife.

Who will now say that Buffalo is not a medical center? Four medical journals are now published here. We have two medical colleges, where twenty-two professors and twenty-one lecturers dispense their medical lore. Besides the regular city and county societies, there are now four private medical clubs, not including the homœopathic organizations.—*Buffalo Medical and Surgical Journal.*

Dr. George H. Cairnes, a well-known and highly esteemed practitioner of Woodberry, Md., has fallen heir to a responsible political position in the office of U. S. Marshal. Dr. Cairnes has enjoyed a large professional patronage and has shown an eminent ability in conducting his private and professional interests. We have no doubt of his eminent capacity for serving the Government in the office of Marshal.

Dr. Brinton H. Warner, aged 31 years, a graduate of medicine and of dentistry, died in this city, on April 6th, with hydrophobia, after three or four days illness. The wound was inflicted by a small dog, which gave no evidence of being rabid, about three months ago. The wound was cauterized with nitric acid at the time and the dog was killed. Dr. Warner manifested from the date of the injury great anxiety and an apparent dread of hydrophobia. He diligently read the literature of the subject and was greatly interested in Pasteur's experiments. His attending physicians pronounced his case one of genuine hydrophobia. His death resulted from exhaustion incident to the disease.

Original Articles.

THE VALUE OF BINIODIDE OF MERCURY AS AN ANTISEPTIC IN OBSTETRICS.—SECOND PAPER.*

BY EUGENE P. BERNARDY, M.D., OF PHILA.

At a meeting held June 4, 1885, I had the pleasure of reading before this Society a paper on the "Value of Biniodide of Mercury as an Antiseptic in Obstetrics." It was with hesitancy that I brought forward the claims of a new agent whose properties were at that time comparatively unknown. My only knowledge of its effects was that which I had derived from reading the experiments of Dr. Miquel, of France, and from my experience in three cases. To-night I again bring it to your notice, not as an unknown and untried antiseptic, but as one which has proved itself far superior to any of this class of preparations which I have thus far used in obstetric practice.

Since writing my first paper, I have learned that the biniodide of mercury has been used for the past year in preference to all other antiseptics at the Lariboisière Maternité of Paris, and the reports of the results obtained have likewise been highly favorable.

In a letter written by Dr. Thomas Linn from Paris, France, to the *Philadelphia Medical Times* (March 6, 1886), referring to the subject of antisepsis, the following passage occurs:

"Professor Panas has again something to say about antisepsis in eye-surgery, principally in the treatment of cataract. The principles that guide him are, first, to make use of an antiseptic that is *sure* and *not irritating* in its action. . . . Of all the antiseptics which he has used during the last two years, Dr. Panas has now definitely adopted a solution of the biniodide of mercury in 20 to 1000 ($\frac{1}{20}$ to 1000 ?).† Even in 40 to 1000 ($\frac{1}{40}$ to 1000 ?), this salt possesses a very strong anti-fermentative power, so that at double the strength nothing should resist it. . . . . As to the other antiseptics used: boric acid is not irritating, but its antiseptic power is doubtful; the bichloride of mercurry is more irritating than the biniodide, and its anseptic power is not half so great."

These remarks fully substantiate the opinion expressed in my former paper, that "I considered the biniodide of mercury far superior to the bichloride of mercury as an antiseptic." Of course, the cases of Dr. Panas belong to eye-surgery; but still the experiments made in both classes of cases led to the same conclusions.

I have here the history of eight other cases in which I found it necessary to use the biniodide. I have perhaps given a fuller detail of circumstances than may appear necessary. If I so erred, I have done it for the purpose of fully and clearly showing under what conditions the antiseptic was used.

It will be observed how readily offensive odors disappeared after only a few injections of the biniodide. In some of the cases the ordor around the patient was perfectly horrible.

Case I.—On September 9, 1885, I was requested to attend Mrs. F., residing at Fifty-fifth and Vine Streets, in her fifth confinement. Her previous labors had taken place in Belgium, and had always been terminated by the forceps, only two children being born alive. The first and third lyings-in were complicated by attacks of puerperal fever.

I arrived about 2 P. M. Found the patient had been in labor since the previous evening (8 P. M.). On examination, found the os completely dilated, head presenting; while to the left I felt what seemed to be a prolapsed cord. The head seemed jammed between the promontory of the sacrum and the pubes. I ruptured the bag of waters so I could make a more decisive examination. Down came a loop of non-pulsating cord, which proved to be irreducible on account of the position of the head. The presentation was now made out to be a partial brow; an antero-posterior contraction existed; the promontory of

*Read before the Obstetrical Society of Philadelphia, April 1, 1886.

†Evidently an error in proportion, as in the formula given it is 1-20 gramme to the litre, or 1 to 20,000.

the sacrum caught the side of the head and pinned it in position. I attempted to push the head up, but soon found it could not be done. I then attempted to produce flexion, and failed. Wallace's forceps met with similar results; on ac count of the unnatural position of the head, the forceps constantly slipped. By this time I was completely exhausted. I gave one-half grain of morphiæ sulph., which would insure the patient needed rest, as her pains had all along been active.

On my return at 5 P. M., found the condition of things the same. Dr. A. E. Roussel, who came with me, etherized the patient. I again attempted to change the position of the head, but failed. Pagot's long forceps were applied, but on the slightest traction they would slip. Tarnier's forceps seemed to grasp the head in a firmer manner, but they finally gave way. I had now worked continuously for two hours. Seeing there was no other resource, I perforated the head, and within twenty minutes the child was extracted, which weighed, without the brains, fifteen and one-half pounds.

The patient was living on the second floor, in a room partitioned off the main room of a factory. The room was well located and freely supplied with fresh air; her husband was the nurse. The next day found the pulse 100, temperature 101°; extreme tenderness over the abdomen, especially over the region of the uterus. I washed out the uterus with the $\frac{1}{15000}$ solution of the biniodide of mercury, and left orders to have it done four time a day. The second visit found the patient free from pain; pulse 80, temperature 98⅘°. Convalescence went straight on as in a normal labor. On the fourth day there was considerable pain over the uterus. Towards evening, while washing out the vagina, a clot of blood about the size of a pigeon's egg was expelled, perfectly free from odor. The patient was up on the eighth day.

Case II.—Was called (October 5, 1885) to attend Mrs. Mc., age 30, third confinement. After an easy labor she was delivered of twins. The placenta came away naturally, and everything went well up to the evening of the sixth day, when she became suddenly feverish and thirsty. The vaginal discharges became highly offensive; so much so that the windows had to be constantly kept opened. I immediately ordered injections (hot) of the $\frac{1}{10000}$ solution of the biniodide of mercury, asking the patient to note particularly when the odor disappeared. The first injection was followed by no effect; but on the second injection being made, the odor disappeared and remained so during convalescence. Discharged on the tenth day, well.

Case III.—On the morning of October 7, 1885, I was called to attend Mrs. B., age 28, sixth confinement. About a month previous she had called at my office, and I had given my opinion that the child she was carrying was undoubtedly dead, and that she was likely to fall in labor at any time. On my arrival at the house, found, after examination, the os perfectly dilated and the bag of waters protruding between the vulvæ. Ruptured the bag of waters, and of all stenches I never smelled the like. The windows had to be thrown open. On pushing my examination, found a small hydrocephalic child descending. Labor was lingering, but finally the child (in a putrid condition) was expelled naturally. The placenta came away without any trouble.

I ordered the patient to be washed out with $\frac{1}{10000}$ solution of the biniodide of mercury four times a day. The first injection I administered myself. The second and third injections were followed by a slight stinging sensation, which I believe came from using water which was too hot; but to make certain I reduced the biniodide to the $\frac{1}{80000}$. Within two days the discharge became perfectly odorless. Each injection was followed by a feeling of ease and comfort. Discharged well on the ninth day.

Case IV.—On October 23, 1885, I was requested to attend Mrs. R., in her fourth confinement. Her third lying-in had been followed by a severe attack of puerperal fever. Upon examination, found the os rigid, dilated about an inch; waters ruptured; vertex presentation,

right occipito-posterior position. Labor was lingering, os remaining somewhat rigid. About 9 P. M., finding that no headway had been made, and the patient by this time commenced showing symptoms of exhaustion, she was then fully etherized. I then applied Wallace's forceps and delivered her of a living child; no laceration. The next day she complained of pain over the region of the uterus. Ordered one-eighth grain morphiæ sulph. in tablespoonful of camphor-water every two hours. On my next visit found the tenderness had increased and the discharges from the vagina were becoming offensive. Ordered hot injections of the $\frac{1}{1000}$ solution biniodide of mercury. The following day the discharges were free from odor, the tenderness of the uterus abated. Discharged well on the fourteenth day.

Case V.—On the morning of November 3, 1885, I was asked to see Mrs. C.,—first confinement. In this patient a year previously I had dilated a constricted os. Pregnancy was ushered in with marked kidney-trouble: the urine yielded over thirty per cent. of albumen. The patient was enormously swollen from dropsical effusion. The case from the start was not a promising one. On arriving at the house, found the patient very nervous; on examination, found the os slightly rigid, but dilating, the waters ruptured; labor dragged on slowly all day, with very little advance. Towards twelve, midnight, she suddenly went into a spasm; I immediately etherized her; by the time she was completely etherized Dr. Curtin, whom I had sent for, arrived. On examination the os was found dilated, slightly rigid; the ether was pushed, with the effect of softening the os. I then applied Simpson's forceps, but they would not hold; Wallace's long forceps were applied, and in a short time the patient was delivered of a fine bouncing boy; no laceration.

The next visit found the patient doing well; pulse about 80, temperature normal. On my second visit the temperature was 102°, pulse 120-130, great fever, excessive tenderness of the uterus, the discharges very offensive. This sudden change was caused by the stupidity and incompetency of the nurse. The nurse being discharged, the mother of the patient undertook to nurse her. I immediately ordered hot injections of $\frac{1}{1000}$ solution of biniodide of mercury. The second injection the odor disappeared, but in this case did not remain away; I believe it was on account of not having a competent person to use the injections. Even as imperfectly as my orders were carried out, the biniodide held the odor under control, as the discharges were never as offensive as before its use. The patient was discharged well on the fifteenth day.

Case VI.—On November 11, 1885, I attended Mrs. L. in her fifth confinement; her last two confinements had been followed by puerperal fever. She had been delivered by an excellent and careful obstetrician. She dreaded the present confinement. On arrival found the child was born; in a short time the placenta came away. The next visit found the patient doing well, with the exception of some tenderness over the uterus. Being compelled to leave the city, I handed the case over to Dr. A. E. Roussel. On his first visit the patient was feverish, pulse 100, temperature 101°, discharges extremely offensive, excessive tenderness over the uterus. Internally, two grains of quinia and one eighth grain morph. sulph. were ordered every three hours, and four times a day hot injections of the $\frac{1}{1000}$ solution of the biniodide of mercury. On his next visit found the patient better and the discharges free from odor. The patient was discharged on the ninth day well, feeling satisfied that the *red pills*, as she called the pellets of the biniodide, had saved her from another attack of puerperal fever.

Case VII.—Mrs. B., on December 28, 1885, miscarried about the fifth month. On my arrival at the bedside, found the fœtus had been expelled early during the day; the hæmorrhage had been excessive; on examination, found shreds of placenta in the vagina, could detect a larger portion in the uterus; the patient declined any interference, stating that it would come away itself. The patient lived in a small ill-ventilated

house, up a court, having for nurse the neighboring women. Gave freely of ergot, but without effect; within twenty-four hours the odor from the vaginal discharges was highly offensive; ordered the $\frac{1}{4000}$ solution of the biniodide of mercury to be thrown upon the vagina four times a day; a few injections readily dissipated the odor. On the fifth day the remaining portion of the placenta came away, free from odor. The patient was discharged well on the tenth day.

Case VIII.—On March 20, 1886, I was requested to attend Mrs. ——, wife of a physician. On my arrival at the house, found that labor-pains had set in about 4 A. M. Saturday morning; examination showed the os soft and dilating, waters broken, vertex presentation; labor continued throughout the day, and terminated naturally at 10.15 P. M.; no rupture of the perineum, but the mucous membrane of the vagina, just behind the posterior fourchette, yielded to the extent of half an inch; there was a tendency to post-partum hæmorrhage, which was readily checked by compression and the administration of ergot. Next day: pulse 92, skin rather hot, natural flow from the vagina. On my next visit, Monday, March 22, pulse 130, temperature 103½°, pain over the left side of the uterus; the uterus appeared flabby, not having well contracted. Same day at five o'clock, pulse 130, temperature 104°, discharges from the vagina highly offensive. Ordered the vagina to be washed out with a solution of carbolic acid (twenty per cent), ten grains sulphate of quinine morning and night, and twenty drops of tincture of digitalis every three hours. Midnight, same day, pulse irritable, quick, and compressible: pulse 128, temperature 103°, the discharges from the vagina still offensive. Next morning, temperature and pulse the same; no change. Ordered the $\frac{1}{4000}$ solution of the biniodide of mercury to be thrown up the vagina, and if possible into the uterus; the injections were administered by the husband, and were thoroughly applied. On the 24th the condition of the patient seemed improved: temperature 102°, pulse 115–120.

On the next morning the husband called at my house and informed me that his wife was in everyway worse; the pulse was so irregular that he could not count it; temperature 104°; patient vomited several times; tendency to diarrhœa. I asked Dr. Goodell to meet me in consultation. On arriving at the bedside of the patient, found her in a remarkably good condition; pulse 100, temperature 102°; examination showed slight laceration of the mucous membrane in the vagina, uterus was contracted; treatment to be continued, with this addition if the case did not get along well: to use ten-grain vaginal suppositories of iodoform in conjunction with the biniodide injections. These suppositories were not used, as the case from this day did well, with this exception, that on the 27th of March, or the seventh day of confinement, she was allowed to get up and use the night-vase. This was followed by a severe secondary hæmorrhage, which was checked by hot-water injections and ergot. From the time the biniodide was used the vaginal discharges were free from any offensive ordor, and it seemed to have a decided influence on the temperature. The patient is still under treatment.

We have here eight cases added to the three of my first paper, making in all eleven cases. This certainly gives us sufficient data to draw conclusions.

The deductions drawn from my early cases are fully sustained by my subsequent experience, and in my mind fully establish the value of the biniodide of mercury as an antiseptic in obstetric practice.

In my first series of experiments, to make my solution of the biniodide I took one and three-quarter grains of the salt, placed it in a mortar, and gradually broke up its particles, after which I slowly added one pint of boiling distilled water. This gave me a $\frac{1}{4000}$ solution. This took a long time, and often alcohol had to be added to dissolve the mercury.

Mr. J. F. Hays, of St. George Pharmacy, conducted a series of experiments for the purpose of placing the biniodide in the hands of the physicians in a convenient and readily-soluble form. To ob-

tain this end, pellets were made of three different strengths. In making them sufficient iodide of potassium was added for the purpose, though not enough to cause any chemical change with the biniodide. The following is the method pursued in making the pellets. Both salts should be perfectly dry. The potassium iodide is first placed in a mortar which has been slightly warmed (just enough to take the chill out of it), and thoroughly powdered; the biniodide is then added and well mixed, but not rubbed hard, or the powder will be apt to cake. Care must be taken not to compress the pellets too hard; they keep just as well and are more easily dissolved when they are compressed just hard enough to make a firm pill. The following is the formula for the pellets:

$\frac{1}{4000}$ = mercuric iodide $3\frac{2}{25}$ grains, potassium iodide 2 grains. Mix as above, and compress in pellet.

$\frac{1}{8000}$ = mercuric iodide $1\frac{23}{25}$ grains, potassium iodide $\frac{3}{4}$ grain. Mix as above, and compress in pellet.

$\frac{1}{15000}$ = mercuric iodide $1\frac{6}{2500}$ grains, potassium iodide $\frac{1}{2}$ grain. Mix as above, and compress in pellet.

In this form the preparation can easily be carried in a satchel. When required for use, one pellet is to be added to a quart of hot water (110°). It dissolves easily, and does not stain the clothing or bedding.

The strength which I generally use is the $\frac{1}{4000}$. Should it appear too strong, the pellet can be cut in half or twice as much water used, thus giving a $\frac{1}{8000}$ strength.

A UNIQUE CASE OF HERNIA.*

BY R. H. P. ELLIS, M.D., OF BALTIMORE.

Mr. B., aged 39; small in statue, and by occupation a picture-frame manufacturer, after some moderate lifting on December 1st, was seized with pain in lower part of his abdomen.

Late upon the same day I was called to see him and found him suffering from a small inguinal hernia or bubonocele of the right side. This was reduced by taxis with no very great amount of resistance and followed by a few doses of opium which gave complete relief.

On the following day, December 2d, he expressed himself as feeling comfortable and wanted to get up, but as it was Sunday, I advised rest in bed to be followed next day by a truss. At my visit on the following morning, December 3d, he was still pretty comfortable and said in a pleasant way that he thought possibly I had mistaken a less serious ailment for a hernia. As to the correctness of my diagnosis, however, I was perfectly convinced, and warned him of the danger he would incur by failing to wear a truss. He had had no alvine evacution since three days prior to the accident and insisted that I should give him a cathartic. As I had known him on several previous occasions to suffer from obstinate constipation, and not recognizing the presence of any positive contraindication, I allowed him, at his own suggestion, to take a dose of castor oil, and directed that this be supplemented with an enema. Of course this attempt to purge would not have been allowed, had I had any reason to doubt the complete reduction of what was, even at first, an extremely small hernia.

December 4; no stool had occurred, although the oil had been taken and an enema administered.

Prior to this time no pyrexia had been present nor scarcely any appreciable change in character or frequency of pulse.

Later in the day the first alarming symptoms showed themselves in the occurrence of pain and tenderness upon pressure, in lower part of abdomen, with acid evacuations, pointing unmistakably to some form of serious abdominal mischief. Pulse became 100 per minute with some tympanitis. Thus it was evident that my patient's condition was becoming progressively alarming.

At this junction of the case I had my friend Dr. G. G. Rusk to see it with me. After a most careful examination he was unable to verify the existence of an unreduced hernia, and thinking it possible

*Read before the Baltimore Medical Association March 22, 1886.

that some other form of intestinal obstruction, perhaps invagination, existed, advised that we should attempt to assist nature a step further, and accordingly suggested rectal injections of chloral hyd. to more thoroughly relax the muscular system, and 1½ grs. does of calomel every half hour to relieve nausea. With this we left him for the night, directing that if his symptoms were not very greatly improved by 5 o'clock next morning, we were to be notified, and would then, probably, open the abdomen and search for the source of difficulty.

Early next morning he was reported as having slept about three hours during the night and some nourishment taken had been retained, otherwise his condition was not materially changed.

Dr. Rusk and myself were early at his bedside and decided to make an incision at the suspected point, *i. e.* where the bubonocele had at first been detected. A few touches of the scalpel and our search was rewarded by the finding of a small button-like portion, or knuckle of the intestine, firmly held within the internal abdominal ring.

Here then was the whole matter explained by the fact that while the original hernia was believed to have been completely reduced, yet there was this portion remaining strangulated, although so small as to defy detection by the most diligent and careful palpation. It is this feature of the case that renders it unique in my experience, viz: that in any case of hernia, after reduction has apparently been effected a small portion of the intestine may remain unreduced, and its presence unverified without an operation. In the case in question the abdominal ring was enlarged and the constricted bowel relieved.

The operation was followed by a favorable modification of all the symptoms present; pulse fell to 90 per minute and increased in volume; vomiting ceased. The wound was closed with silver sutures and dressed with frequently repeated cold carbolized compresses.

A teaspoonful of Valentine's beef juice in wineglass of water every three hours, was the only alimentation allowed at first. Three thin stools followed during the first six hours succeeding the operation, but were promptly checked by opium. Pain and restlessness were relieved by morphia hypodemically. Every feature seemed propitious until the afternoon of the second day succeeding the operation, when the stools became frequent and were checked only after free use of suppositories of plumbi acetas et opii. Vomiting and great tenderness upon pressure announced the occurrence of extensive peritonitis. Large linseed-meal cataplasms were applied over the abdomen and covered with oiled silk, opium was used as free as deemed prudent, nourishment and stimulants were assiduously administered per orem and rectum, but in spite of the most persistent attention given to the last, his condition increased in gravity, and death closed the scene on the night of the fourth day after the operation.

If the symptoms present had unmistakably indicated a strangulated hernia, the operation would have been performed at an earlier date, and of course with much greater likelihood of success.

The delay was entirely due to the belief that the hernia had been wholly reduced.

In cases where the symptoms present clearly indicate intestinal mischief without indicating the locality or exact point, and nature of the trouble, surgeons generally recommend and exploratory operation. But in such a case as the one I have here mentioned, where the hernia was easily, and apparently completely reduced, followed by a subsidence of the former symptoms, and even when nearly two days later, more severe symptoms came on, but without any special degree of pain or effort to vomit being produced by pressure over the suspected point—under such circumstances should we not hesitate before entering the sacred confines of the abdominal cavity? Might not an amount of traumatic peritonitis accidentally occur after the reduction of a hernia sufficient to cause symptoms resembling intestinal obstruction, and which, by judicious medication and rest would be readily recovered from, whereas an oper-

ation under such circumstances would almost certainly result fatally? It seems to me quite rational to believe such a complication possible, and in the case here referred to, constituted another reason for the conservative course pursued.

The question as to whether the knuckle of intestine found strangulated at the operation, was reproduced after having been reduced, or whether it had never been entirely reduced at all, I leave an open question for the eminent surgeons here to-night to answer.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MARCH 5, 1886.

Dr. W. P. Chunn reported a case of

KOLPO-CYSTOTOMY.

The term kolpo-cystotomy designates an operation for the institution of an artificial vesico-vaginal fistula, and is produced for the relief of chronic cystitis. He first witnessed its beneficial action in a case treated by Professor Wm. T. Howard, where there was much annoyance from frequent micturition and positive relief from the operation.

Dr. Chunn's case was similar in character. He operated on his patient about three months ago in the following manner. The woman was placed in Sims' position, a sound introduced through the urethra to just within the bladder, a fold of the vesico-vaginal septum was caught up with a tenaculum and the opening made at the most dependent portion of the bladder. The edges of the wound were touched with a solution of per-sulphate of iron to prevent their primary union; this opening was subsequently kept open by the introduction of a sound once or twice a week. It has now been about three months since the operation was done and the patient is very comfortable, having been relieved of the annoying incessant dribbling of urine.

Dr. J. H. Branham asked if benzoic acid and tr. belladonnæ, used by Dr. Chunn before the operation, were the only remedial agents employed before resorting to the surgical procedure. He thinks in addition to them benzoic acid should have been given internally and the bladder frequently washed out with a solution of boracic acid. Also asked if after the operation the hypertrophied bladder walls had atrophied.

Dr. B. B. Browne said that a very large majority of the cases of cystitis in the female were accompanied by a diseased or morbid condition of the urethral tract and frequently caruncular growths and fissures exist which keep up an irritable condition of the urethra, and lead to patients retaining their urine for a very long time so as to avoid the pain which they endure while passing it; in consequence of this the bladder becomes overdistended and paralysis of its walls results, the residual urine becomes ammoniacal and cystitis is set up. In such cases kolpo-cystotomy of course would give relief so long as the bladder was drained by this means; but so soon as the artificial fistula was closed the cystitis would sooner or later recur, and continue as long as the previous morbid condition of the urethra exists. From a careful observation and study of a large number of these cases for the past twelve years he is well satisfied that this is the explanation of the cause and return of the cystitis. He has had perfectly satisfactory results with dilatation of the urethra and removal of the caruncular growths, when they exist. He has never had incontinence of urine follow dilatation and thinks that the strong statements that have been made in regard to the danger of the operation are more theoretical than practical, as they have only been made by those who condemn the operation and never practise it, and consequently have not much experience with it, whereas others who have dilated the urethra most frequently have had no bad results. As far as the comfort of the patient is concerned, forcible dilatation, which at once overcomes the spasmodic condition of the urethra and allows the woman to retain and pass her urine at will, and free of pain, is certainly preferable to kolpo-cystotomy with

subsequent dribbling of urine through the vagina for several months and then with an almost certainty of the cystitis returning as in the cases related by Dr. Chunn.

Dr. Browne related several cases of cystitis treated by dilatation and removal of fissures and caruncular growths from the urethra, and referred to a paper on this subject which he read before the Medical and Chirurgical Faculty, and published in the Transactions of 1880, p. 135.

Dr. Chunn, in replying to Dr. Branham, said he thought his question pertinent, but confessed to not having used the remedies advised by him. He gave as his reason, that the woman had been under the care of several competent physicians at different times, and he took it for granted that *they* had employed the full list of therapeutic agents to no avail. Moreover the patient could not be conveniently seen every day and the case had proceeded to a such decidedly chronic stage that he thought an operation held out greater inducements. In reply to Dr. Browne he thought dilatation of the urethra gave good results in simple irritability of the bladder or where there were growths in the urethra or bladder.

RADICAL CURE OF INGUINAL HERNIA.

Dr. Randolph Winslow who was to have reported a case of radically cured inguinal hernia and presented the patient, said he had found upon examining the patient recently that he still had some slight protrusion, although not sufficient to require the use of a truss; he therefore refrained from reporting it as a case of radical cure of hernia. Thinks had the patient worn a truss for some time after the operation that it would more likely have been a radical cure. In performing the operation he had ligated and cut off the sac after the strangulated bowel had been relieved and returned.

Dr. J. W. Chambers asked what effect dissecting out the sac had on the mortality. What were the advantages?

Dr. R. Winslow said as to the mortality, he did not know. Dr. Bull, of New York, had cut off the sac with a view to radical cure and his patient had died, but thought generally it did *not* increase the mortality.

Dr. R. M. Hall had seen Dr. Richardson, of Boston, operate for strangulated hernia, and asked him if he thought cutting off the sac would result in a radical cure. Dr. Richardson did not think it would.

MENINGEAL HÆMORRHAGE IN THE NEW-BORN CHILD.

Dr. J. H. Branham exhibited a specimen of a brain of a new-born infant in which there had been a meningeal hæmorrhage. The child had lived about forty-four hours. There were no symptoms except stertorous breathing and coma just before death. Autopsy revealed a large clot on the right side, the result of the rupture of a small vein near the extremity of the lambdoid suture. A portion of this clot was firm, while the remainder was semi-fluid or fluid.

Dr. R. Winslow: What is thought to be generally the cause of convulsions in the new-born?

Dr. J. H. Branham: Sims ascribed them to meningeal hæmorrhage.

Dr. Chambers: Had there been any convulsions in the case under consideration?

Dr. Branham: There had not.

Dr. Winslow thought Dr. Sims had ascribed such convulsions to a displacement of the occipital bone.

Dr. Branham thought that as some of the clot was fluid and the balance firm, it was evidence that the hæmorrhage had been slow.

IMPERFORATE ANUS.

Dr. H. H. Biedler next reported a case of imperforate anus. The case was that of a boy about three years old, to whom he had been called a few weeks since. He found the patient had been operated on some days after birth with only partial relief, the opening only admitting a No. 8 sound. The patient was suffering very much from intestinal obstruction, as was evinced by an enormously distended abdomen.

He made a perineal incision of about .75 of an inch, into which he passed his finger to the distance of about 2.5 inches. Not being able to make out anything definite, he desisted from further operative procedure. The patient died on the following day. Autopsy revealed the rectum to have ended in a narrow fistulous opening about 2.5 inches from where the anus should have been. It was attached by several fibrous bands to the sacrum, and was distended to about eight times its normal size.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD APRIL 1, 1886.

The President, B. F. Baer, M.D., in the chair.

Dr. E. P. Bernardy read a paper on

THE VALUE OF BINIODIDE OF MERCURY AS AN ANTISEPTIC IN OBSTETRICS.*

DISCUSSION.

Dr. Chas. Herman Thomas had heard the statements of Dr. Bernardy with interest and surprise that cases of so much gravity could be controlled by such simple means as vaginal injections. His practice and belief has been that such cases require the introduction of washes into the uterus, the washing of the vagina being utterly futile; the doctor related an instance in which a four para was allowed to die of septicemia, no effort being made to wash out the uterus, although vaginal antiseptic injections were frequently employed in the case. Six weeks have elapsed since the death of that patient and in that time the same practitioner has lost three additional parturient patients.

Dr. Longaker spoke in support of Dr. Bernardy's practice. We have been led to expect a prompt fall of temperature from the use of intra-uterine injections in septicemia post-partum. His own plan is to discontinue intra-uterine injections after the first thorough washing, unless offensive discharges come from the uterus. He has observed that after the repeated introduction of forceps into the uterus, the introduction of the hand or other means favoring the introduction of air, a peculiar traumatic metritis results, and to relieve this he has been in the habit of introducing into the uterus an iodoform pencil, containing about 1⅔ drams of iodoform; this prevents future sepsis (See Lusk, last edition). Prompt lowering of temperature and pulse are the result if this is used after sepsis has occurred, and even when antiseptic uterine injections have failed. The effect of one of these pencils will last through two or three days, when another may be needed.

Dr. Howard A. Kelly drew attention to the fact that the biniodide of mercury is almost if not entirely isoluble in water and that an alcoholic solution would scarcely be admissible. He also called attention to the frequent presence of the bichloride as an impurity. He read the following letter from Dr. Francis L. Haynes:

"In reference to the potassio-mercuric-iodide, I may add a little to the facts I mentioned in our conversation. The last case of puerperal septicæmia I have seen in my own practice, occurred in Mrs. F., confined December 18, 1885. It was due to the fact that my hands were contaminated with septic matter and that I trusted entirely to hard scrubbing and to inunction with oil of turpentine to purify them (After Goodell). In this case the pulse was 138 and temperature ran up to 105°, but she recovered in a few days under copious injections of hot water into the uterus (generally plain but sometimes with a little carbolic acid added). These injections were given, and during the days on which this treatment was being used I attended several cases of labor, purifying myself with 10 per cent. solutions of carbolic acid. These cases had no trouble; but I became ill, as I always do when I use much carbolic acid, and my hands became sore. I now began to use the potassio-mercuric-iodide solution to purify my hands and since then have had no trouble whatever, al

*See page 477.

though I have attended cases of labor within a few hours after (1) washing out the uterus of a patient of Dr. L.'s suffering from septicæmia (terminating fatally); (2) after amputating finger and metacarpal bone of a man suffering from gangrene of finger and suppurative cellutitis of the hand and wrist; (3) after digging out putrid placenta after miscarriage (several instances); (4) after performing autopsy in a case of suppurative peritonitis and bathing my hands freely in the pus. The solution may be used without apparent injury to purify blunt instruments, and it is certainly a great comfort to soak your speculum thoroughly in it after treating a case of gonorrhœa.

How is the solution prepared? A four-ounce bottle is marked with a diamond so as to indicate drachms and filled with distilled water containing ʒi each of potassium iodide, and mercuric iodide (The cost of this solution is less than ten cents). It is now a very easy matter to make a solution of any desired strength extemperaneously: A tablespoonful to the pint = one part to 1000 is the strength I generally employ, but after ausopsies I use one to five hundred.

How do I prevent my hands from becoming eczematous when using this solution? Once or twice daily after washing the hands and while they are still damp, about one-half ounce of glycerine is poured into the palm and thoroughly rubbed into the whole surface of the hands which are then dried as usual. This is very effectual."

Dr. Wm. Goodell has had no experience with biniodide of mercury, but has had with bichloride. He is not sure that Dr. Bernardy is at fault in confining his antiseptic injections principally to the vagina, for where does sepsis usually take place? Not in the uterus but through wounds of the vagina. In the Charlotte Hospital they have good results from the use of bichloride injections and iodoform. When the Preston Retreat was new they had a good record, but afterwards the percentage of fatal cases became too large. This fault was remedied by the use of bichloride of mercury as a vaginal injection and the introduction of ʒi of iodoform The pads to catch the lochial discharges were replaced by absorbent cotton medicated with corrosive sublimate. In the last one hundred and forty cases no rise of temperature has occurred during the puerperal period. In these cases the antiseptic applications were all directed to the lower portion of the womb and the vagina. Dr. Bernardy is probably right. A solution of 1 to 2000 is too strong and will produce soreness after operations. He does not like to have the patient on her side during and after the removal of the after-birth as it favors the entrance of air into the vagina, as in Sims' position. She should be on her back.

Dr. Harris inquired if Dr. Bernardy did not use uterine injections after the removal of the dead fœtus. The effect of a decomposing fœtus with unbroken membranes, within the uterus, has a remarkably prostrating effect upon both mind and body of the mother.

Dr. Githens described a case of post-partum septicemia in which an offensive leucorrhea, which had existed before labor and which had been neglected was the apparent cause. In this case vaginal injections of potassi-mercuric-iodide quickly relieved the undersirable symptoms.

Dr. Thomas thought vaginal injections would be quite sufficient as a prophylactic agent, but would it be considered sufficient if septic peritonitis were present? One thorough uterine wash first and then iodoform pencils to prepare for subsequent vaginal washes. In Bellevue Hospital uterine injections are always used when vaginal washes failed to reduce the temperature.

Dr. Bernardy uses the first injection himself and thoroughly washes out the uterus and continues the injections until the fluid comes away perfectly clear. The firm contraction of the uterus eliminates the liability of absoption there and the principal abrasions and absorbing sufaces are undoubtedly vaginal. The results at least have been satifactory.

The pellets exhibited are quite soluble and chemically pure; the biniodide has been tested for bichloride and none is

present. The potassium iodide present merely aides in the solubility without affecting the chemical composition of the mercuric iodide.

Dr. Wm. Goodell read a paper by Dr. Hiram Corson on the statistics of 3036 cases of labor.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD MARCH 22, 1886.

The President, Dr. W. F. A. Kemp, in the chair; J. M. Hundley, M.D., Secretary

PNEUMONIA IN AN INFANT.

Dr. J. I. Pennington related the following case:

He was called on the evening of the 12th, to see a child 9 months old; it had quite a high fever; mucous râles could be head over the chest, percussion clear and auscultation difficult to obtain, as the child was very restless. The following morning, the temperature was 104°, pulse greatly increased in frequency, percussion clear, auscultation still difficult to obtain, and cough much worse. He now ordered ½ gtt. doses of veratrum viride and some whiskey to guard against the depressing effects of the veratrum; following morning the symptoms were aggravated; temperature 105°; now gave quinine in addition to the veratrum. On the next day no improvement; the quinine was discontinued. Auscultation and percussion still unsatisfactory. The case so continued till the evening of the 18th, when hot moist applications were ordered applied to the chest and the veratrum continued. On the following morning the child was much improved; pulse and temperature near the normal. Dr. P. thought this a case of pneumonia, though he could not be positive as auscultation and percussion were both unsatisfactorily obtained, owing to the restless condition of the child. An interesting point in the case, was the rapid subsidence of the symptoms present after the application of the hot moist cloths. Could such a favorable termination be attributed to the moisture or was it due to crisis?

Dr. S. T. Earle asked what time subsidence of fever, etc., took place.

Dr. Pennington said he was called to see the patient on the 12th and crisis occurred on the 19th.

Dr. C. H. Jones said he thought the pneumonia must have been complicated with pleurisy, as he had noticed the temperature in pneumonia rarely ran so high unless complicated.

Dr. Pennington said he really did not make out the case clearly, but based his diagnosis upon the fever and general symptoms.

Dr. Earle said the fever in apex pneumonia usually ran much higher than pneumonia elsewhere.

RETAINED PLACENTA AFTER ABORTION.

J. E. Gibbons said he would like to ask the gentlemen present how they would treat the following case. He was sent for to see a woman and found after arriving that she had had an abortion; probably the pregnancy was of two and a half months duration. The fœtus had been expelled but the afterbirth still remained *in utero*, though he made an examination and could find nothing; the examination, however, was not satisfactorily made. He ordered the patient to bed and gave ergot in the hope that the uterus would throw off anything remaining; but it did not—now he wished to know would he be justified in dilating the cervix, not knowing positively that there remained the placenta. She had no discharge since the first few days of any kind and is now doing well.

Dr. J. H. Scarff said a practitioner of this city of large experience and good standing had been sued only a few weeks ago by the husband of a woman dying of septicæmia, induced by the remianing *in utero* of the placenta after abortion. He would advise Dr. Gibbons to dilate the cervix and curette the uterus if there occurred any bleeding or discharge of any kind.

Dr. Pennington asked Dr. Scarff if

he had ever seen septicæmia follow an abortion at two and a half months gestation.

Dr. Scarff said he had, and only a few days ago.

Dr. C. H. Jones said he now had under his care a case similar to Dr. Gibbons'. He had never seen septicæmia or any serious trouble occur in these cases and he did not believe in making a too great effort at extraction of placenta. To arrest the hæmorrhage he used suppositories of extract of ergot by bowel and it usually acted better in that way than by the mouth.

Dr. Gibbons said two years ago he had a similar case to this. In it he saw the fœtus, but not the after-birth; in a day or two he made an examination and thought he felt the after-birth. He gave ergot and in three days made another examination and could feel nothing. The woman said nothing had passed. She did well and is now as well as ever.

Dr. R. H. P. Ellis said if we were satisfied there remained any piece of the placenta entire, we should make every effort to extract it, even if we had to dilate. He did not see how ergot in these cases could cause the uterus to expel a peice of placenta; he rather thought it would hinder its expulsion.

Dr. Geo. H. Rohé said some years ago he was the physician to the Woman's Hospital and there he saw a large number of uterine troubles. Most prominent among them were menorrhagia or metrorrhagia, induced by the retention after abortions of portions of placental and fœtal envelopes. He had never known septicæmia to occur in these cases. For the hæmorrhage nothing did so well as dilating the cervix and curetting. From such an experience he considered it our duty always to dilate, if necessary, and take away anything that remained and thus avoid any subsequent trouble.

Dr. C. H Jones wished to know how long utero-gestation had lasted in the cases alluded to by Dr. Rohé.

Dr. Rohé said some two months, others six.

Dr. Gibbons then asked Dr. Rohé if he must infer from his remarks that he should dilate and take away the placeta.

Dr. Rohé said he did not think it needed dilatation; thought it could be gotten away with the finger.

Dr. J. H. Scharff said he corroborated all Dr. Rohé had said.

Dr. E. G. Waters asked Dr. Scarff whether in dilating the cervix he used tests.

Dr. Scarff said he did not; he used rapid dilatation and had never seen any harm result therefrom. The use of tents greatly increased the liability to septicæmia.

OÖPHORECTOMY FOR PROLAPSED OVARY.

Dr. R. H. P. Ellis related the case of young lady sent to the hospital of the Baltimore Medical School, said to be suffering from dyspepsia. She had been treated by seven or eight physicians prior to coming to the hospital. She could take nothing in the way of food, suffering constantly from nausea, and vomiting everything taken. She was much emaciated and in a most deplorable condition. He had her put under the care of Dr. J. H. Scarff, who used every known remedy for the relief of the nausea and vomiting—after using various remedies and no improvement taking place, an examination *per vaginam* was made, a prolapsed ovary was found, tender to the touch, and increased in size, about as large as a hen egg, pressure on which would invariably bring on nausea and vomiting. An effort was made to replace the prolapsed organ, but without success, being bound down by adhesions. Dr. Scarff now decided to operate, and the patient and friends gave their consent. The operation was performed under antiseptic precautions. The pedicle was ligated and dropped back into the abdominal cavity, the wound was dressed antiseptically and healed by first intention. The dressing was only once removed. It is now the seventh day, the patient is without fever and is doing well. There has been no return of nausea or vomiting, which ceased upon the removal of the ovary.

Dr. Earle asked Dr. Scarff if *strict* antiseptic precautions were taken.

Dr. Scarff said they were. The walls of the room were limed washed, sponges were boiled for several hours, and everything coming in contact with the patient was immersed in a solution of carbolic acid or corrosive sublimate. Silk sutures were used and they were put in the sublimate solution.

Dr. Waters said the case of Dr. Scarff's was very interesting and instructive. He had very recently a similar case; the patient suffered with violent nausea and vomited everything as soon as it reached the stomach. The nausea was entirely due to ovarian irritation, as the trouble only occurred at or about the menstrual period. After trying various remedies, the nausea was finally controlled by small doses of calomel and a blister over the epigastrium.

Dr. S. T. Earle said, the success, which now usually attends laparotomy when performed antiseptically, should embolden us to undertake operations which formerly we dared not do.

Dr. Scarff said sometime since he extirpated the ovaries of a woman suffering from epilepsy. She has had no return of the trouble since operation

Dr. Waters related a case where a surgeon in Germany had been sued because he operated and did not use antiseptics. The patient died and the case was decided against the surgeon, for the reason that he did not keep fully abreast with the times; he should have used every recognised means for the ultimate good of his patient.

Dr. Scarff said he did not see how the remarks of Dr. Waters could be reconciled with the views now held by Lawson Tait.

Dr. Earle said Tait used cleanliness in its strictest sense and it was the very best antiseptic.

Dr. Geo. H. Rohé said that Lister regarded the air as the chief source of danger, could we render harmless the germs it contained, he thought septic infection would occur only exceptionally and for this purpose he invented the *spray*. He could not agree with Lister, but rather believed that the germs were oftener introduced into the system by the hands of the surgeon, sponges, instruments, etc.

Dr. R. H. P. Ellis read a paper entitled

A UNIQUE CASE OF HERNIA.*

DISCUSSION.

Dr. S. T. Earle said, while Dr. Ellis pursued a rational course of treatment, it is now an accepted rule that when the symptoms of strangulation continue or recur after supposed reduction, an exploratory incision should be made at once, as a *band* may exist with the hernia.

Dr. Geo. H. Rohé said he had had two cases of femoral hernia in women. In one case he thought he had reduced it, but the symptoms continued unabated. He asked the woman to allow an operation, but she refused until nearly dead, and even then, when they had everything in readiness she again refused and died in a few minutes. A post-mortem was obtained and the smallest possible portion of gut found incarcerated. In the second case the patient complained of severe pain in and around the navel. It was in the summer and at that season when there was an abundance of melons and green fruit, and cramp colics were frequent, all of which misled me for a while. Morphia was administered hypodermically and I left a few doses to be taken in the event the pain did not cease or returned. I was sent for in a short while after leaving the patient; on my arrival I found the pain equally as severe as before and referred to the same region. I now suspected a hernia and made an examination. A strangulated femoral hernia was found, which, by manipulation, was easily reduced, so I thought at the time, though it did not return with that sudden snap we usully hear. The symptoms instead of ceasing, continued, and Dr. O. J. Coskery was called in to operate. The operation was done and a very small half-loop was found strangulated and the patient died.

See page 481.

Dr. Earle said the reason there was trouble after reduction was paralysis of the part incarcerated, and which was unable to free itself of the offending mass perhaps.

Dr. E. G. Waters asked Dr. Ellis if the bowel was gangrenous?

Dr. Ellis said it was not, and only a very small portion of the bowel strangulated.

Dr. Waters said the mere size of the loop of bowel meant nothing. The gravity of the symptoms would be the same and the case as likely to prove fatal as if two feet of bowel were strangulated. He said were he to have a case he should use injections of hot water, repeating them several times if needs be, and give them very slowly. If these failed he should resort to operation immediately. Water, he said, used in the way described and with the buttocks raised, acted wonderfully at times, not only by distending the bowel, but causing it to contract as well.

Dr. Earle said he did not see how the water could do good, as it was usually the ilium involved, and the water could not pass the ileo-cæcal valve. Dr. Tiffany had demonstrated that fact by various experiments on the dead body.

Dr. Waters said he was well aware of the fact as observed in dead bodies, but did not believe it would hold good in the living.

Dr. Ellis said he could not see why the symptoms in his case abated for two days and then returned again.

Dr. Gibbons said he had a case in a woman and reduced the hernia, as he thought. All of the symptoms subsided for a while to return again. The patient died without operation.

Correspondence.

BALTIMORE, April 12, 1886.

Editor Maryland Medical Journal.

DEAR SIR:—Will you be kind enough to correct in your next issue a mistake that occurred through my carelessness in a recent copy of your JOURNAL. Please say that through an inadvertence the writer of the paper on "A Case of Ovariotomy with Hysterectomy," undersigned himself assistant to the chair of Gynæcology. It should have read Chief of Clinic to the chair of Diseases of Women and Children.

Very truly yours,

WM. PAWSON CHUNN.

ABSCESS OF THE PANCREAS AND THROMBOSIS OF THE PORTAL VEIN.—Abscess of the pancreas is of such rare occurrence that the instructive case recorded by DR. J. H. MUSSER, in the April number of *The American Journal of the Medical Sciences*, will receive careful study. Its clinical indications were so meagre that the revelations of the autopsy were surprising, and when the extent of the disease and alteration of structure are considered, it must be regarded as remarkable that the abscess could have existed with so little discomfort to the patient. The pain, the gastric disturbance, and the fever frequent in abscess in this situation were absent entirely. Emaciation, constipation, a tumor, and pressure symptoms were present, it is true; symptoms and signs, however, due to so many causes so much more common than pancreatic disease, that this affection was quite plausibly, therefore, excluded. The latency of the symptoms appears to point to the chronicity of the abscess. The histological appearances of the pancreas, and the sequence of the pus formation, peritoneal adhesions, and thrombosis (from pressure), confirm this view. The rupture of the pancreatic abscess and its limitation to the duodeno-inguinal fossa are believed to be unique.

A GIFT FROM MEDICAL STUNDENTS.—The students of medicine and pharmacy of Marseilles have presented to the hospital administrators the sum of nearly twenty thousand francs, to be applied to the erection of isolating wards for the reception of children suffering from contagious diseases. The money was the net proceeds of a series of balls given by the students in recent years.—*Med. Record.*

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BALTIMORE, APRIL 17, 1886.

Editorial.

THE OPERATIVE TREATMENT OF FACIAL NEURALGIA—Neuralgic affections of one or more branches of the fifth nerve occasion perhaps as agonizing pain as any disease to which humanity is heir, and the inability of drugs to produce more than a temporary palliative effect in their treatment has led to the relegation of the most obstinate cases to the domain of operative surgery. Various operations have been devised and practised with varying degrees of success until the experience of surgeons in the treatment of these affections has accumulated sufficiently to allow of the discussion of the subject in a full and definite manner. Dr. George R. Fowler (*Annals of Surgery*, April, 1886,) has lately published an elaborate study of the subject, which has great historical and scientific value and which will probably rank very high hereafter as authoritative. There are four operations which have been done and which must be considered, viz: neurotomy, neurectomy, nerve stretching and arrest of the blood supply to the part affected. Neurotomy was naturally the first procedure which suggested itself, but its study is now of little or no value from the practical point of view. Its history of blundering performance and failure to achieve more than at most a merely transient success have left it but few, if any advocates among practical surgeons. It may therefore be dismissed as being of mere historical interest. We have learned that cut nerves unite with great rapidity with restoration of function and, in the cases under consideration, with return of pain. Neurectomy has given more brilliant results and has acquired a regular standing among surgical operations. Though done as long ago as the fifteenth century by Marechal, surgeon to Louis XIV, it owes its present position to the labors of Wagner, Carnochan and James R. Wood. Many other great names in surgery are also identified with its history, as Schuh, von Nussbaum, Billroth and Paturban. The necessity of reaching the nearest possible point to the exit of the nerve from the skull has led to some daring surgical exploits, as the dissections of Carnochan, who believed the excision of Meckel's ganglion essential in operations on the superior maxillary branch, the osteoplastic resection of the upper jaw as practised by Nussbaum and Gerster and trephining the antrum by others not referred to by Dr. Fowler. It is desirable to remove as much of the nerve as is possible and especially in centrifugal cases to dissect out as many branches in the peripheral direction as possible, for it is recognised that branches of communication left intact are capable of doing much harm. In central cases it is recommended to stretch the proximal end before excision. Dr. Fowler tabulates eighty-three cases of neurectomy, most of which have been done since the appearance of Wagner's paper. This table gives at a glance the standing of the operation in recent years. Unfortunately the brilliant results which immediately follow the operation are not as permanent as could be desired. At a period ranging from several months to several years, there is a pretty monotonous record of returning pain and the unhappy victim has to submit to renewed mutilations and finally to succumb. Very rarely the relief is perminent. Dr. Fowler sums up all the evidence and concludes, we think wisely and humanely, that the operation should be done even with the knowledge that the relief it gives will not be permanent. Even a short respite from the tortures of the malady is worth much to the patient.

The study of the effect of nerve stretching is much hampered by want of definite data in regard to the period of relief. Cases are reported as cured at six months after operation, which would in many instances be classed as failures at the end of the year. That temporary relief is obtained is indubitable. Moreover the fact that much stretching is a necessity in the performance of neurectomy leaves some doubt as to the share of each in whatever good result is gained. Stretching is supposed to be especially useful in central cases, but the difficulty of exposing enough of any of the branches of the trigeminus sufficiently for the purpose is a great obstacle, and makes the operation almost, if not quite as grave as neurectomy.

Arrest of blood supply was practised by Trousseau. He peformed arteriotomy of small vessels such as the temporal and occipital, and subsequently used compression. Some brilliant successes are said to have followed this method. Carotid ligation, as now practiced, was introduced by Nussbaum and based upon the apparent good result of a carotid ligation for recurrent hæmorrhage after various neurectomies in an obstinate case. The case was fatal from a recurrence of hæmorrhage. Dr. Fowler has collected notes of eighteen cases,showing relief varying from eleven years to two months. One case was fatal and two received no benefit whatever. This operation is naturally the last resort and should only be considered when the others have failed. The fifth, and final conclusion at which Dr. Fowler arrives after studying the subject from all points, is that "No patient should be denied, other things being equal, the chance which any one or all these operations in turn may give him of escaping, even for a short time, the intolerable suffering incident to an intractable or otherwise irremediable facial neuralgia."

On the Diagnostic Worth of Examination per Rectum in Coxitis.—Digital and manual exploration of the rectum has in recent years become a well recognized procedure, not only in cases of rectal disease, but for the purpose of arriving at a diagnosis in obscure conditions within the abdominal cavity. When however the whole hand is inserted into the rectum, the comparatively limited space, and the contraction of the sphincter so cramps the hand that it is not often that much diagnostic worth can be ascertained. Much may frequently be learned in regard to the condition of contiguous parts by a careful digital examination per rectum, and the uterus, ovaries, bladder and prostrate gland can in this way be quite thoroughly investigated. In *Centralblatt für Chirurgie* (March 13, 1886) Dr. Arnold Schmitz, of St. Petersburg, calls attention to exploration by the rectum in order to determine the existence of hip-joint disease, and more especially to learn the part in which it has begun, and has chiefly affected. He says: "The determination of the question from which part of the joint apparatus a tuberculous or osteomyelitic process has taken origin, is doubtless of a significance not to be undervalued, especially in regard to its appropriate treatment. It appears to me then, that sufficient attion has not been bestowed upon a method of examination in inflammation of the hip-joint, which is able frequently to make the most important disclosures. I mean the palpation of the posterior surface of the acetabulum through the rectum."

The histories of three cases are detailed in which both the nature and seat of the disease was ascertained through rectal palpation, and from the knowledge thus acquired an appropriate treatment was instituted. In one case owing to a projection of the third lumbar vertebra there was doubt whether the symptoms were due to spine disease or to coxitis, examination per rectum disclosed a swelling upon the posterior surface of the acetabulum, which had not yet suppurated, and showed the disease to be acetabular. In another case spondylitis was actually present, and there was doubt whether a gluteal abscess was connected with the spinal caries or with disease of the hip; this was settled by a rectal exploration, when an abscess was found

upon the posterior aspect of the acetabulum. In all three cases resection of the head of the femur was performed, the diseased cotyloid cavities reamed out, pus emptied, and sequestra removed. The caput femoris in all the cases was still quite healthy and covered with normal cartilage.

Dr. Schmitz concludes his article as follows: "The foregoing experiences will not permit me in the future to neglect rectal palpation in any affection of the hip-joint."

Decrease of Zymotic Diseases.—The supplement for the decennial period, 1871–80, which has been recently issued by the Registrar-General of Great Britain (*Lancet*, Jan. 2, 1886,) presents a striking confirmation of the value of sanitary measures in reducing the death-rate from zymotic diseases in England and Wales.

From the statistics compiled by the Registrar-General, it appears that the general rate of mortality has, when compared with that which prevailed during the ten years, 1861–70, so far lessened as to exhibit a saving of 1,114 lives annually to each 1,000,000 persons living, and the saving has, to a large extent, been effected by a decrease in the more preventable of the zymotic diseases. For example, the annual mortality from scarlet fever fell from 972 to 716 per 1,000,000; diphtheria exhibited a decrease from 185 to 121 per 1,000,000. The deaths from "fever," which includes typhus, enteric fever, and "simple continued fever," fell from an annual average of 885 to 489 per 1,000,000. The deaths from diarrhœa fell from an annual rate of 1,076 to 935 per 1,000,000, showing an annual gain of 141 lives for each 1,000,000 persons living. Those diseases which are less influenced by sanitary measures show a smaller diminution in the death-rate. The statistics from small-pox show a marked exception to this general decrease, and on the contrary an increase in mortality from 163 to 236 per 1,000,000. This rise is attributed to two serious epidemics which occurred during the decennial period, and in part also to an increase in adult small-pox amongst persons who had not been revaccinated. This increase in mortality from small-pox, occurring in the face of a general decrease in the zymotic diseases, goes to show that apart from vaccination and revaccination reliance can not be placed on an improved sanitary administration to protect against this disease, or as our contemporary puts it, "Apart from the protection afforded by vaccination and revaccination, small-pox is as deadly a disease as it ever was."

Miscellany.

Removal of Both Ovaries During Pregnancy.—Mr. Knowsley Thornton read a paper before the Obstetrical Society of London, February 3, on a case of Removal of both Ovaries during Pregnancy. M. W——, married, aged twenty-two, in the third month of pregnancy, was known to be large twelve months before marriage. She is now beyond the size of pregnancy, and has a large fluctuant tumour in the abdomen, which is growing fast. Has suffered from several attacks of pain in the abdomen, with rise of temperature, sickness, and faintness. Diagnosis: ovarian tumour complicted by pregnancy. Ovariotomy advised, and performed Feb. ruary 4th, 1885. Dermoid tumours of both ovaries removed. Rapid and uninterupted recovery. Premature delivery at eighth month. Labour uncomplicted. Lochia normal. Fine healthy child, and plenty of milk to nurse it. On examination, uterus found atrophic; patient, while nursing, suffering from flushes, chills, &c., just as others do who have an artificial menopause brought on by operation. The author made remarks on the interesting physilogical and pathological problems which this unique case suggests. Dr. John Williams said that in a note read before the Society in 1884 he described the involution of the puerperal uterus in the absence of the ovaries. In that case the left ovary had been removed some years previously, and the right was removed soon after labor set in. The course of the process of involution might have

been affected directly by the interference of the operation in his case; but in Mr. Thornton's it could not have been so, for the operation had been performed some months before labour set in. He would ask Mr. Thornton if any observations had been made on the process of involution in his case. Dr. Routh remarked that the atrophy of the uterus could not impede lactation, and quoted Dr. Livingstone, who stated that the wives of the African kings were not allowed to suckle their own children, as it was thought derogatory. The child was given to the grandmother, generally an old woman, to whose mammæ and pudendum certain plants were applied and the child put to her breasts, with the result that she was able to suckle the child. He also alluded to well-authenticated cases in which men had suckled. He objected to the conclusion that menstruation always depended upon ovulation; this question he considered undecided, and facts were accumulating to show that menstruation had really very little to do with ovulation. Dr. Matthews Duncan regarded tapping as the best treatment in cases of simple parovarian cyst. It involved less danger than extirpation, and was often successful. The extirpation of small papillomatous ovaries involved many difficulties. He did not believe any operation could cure where malignant disease had extended to several different parts of the peritoneum. He also reminded the Society that Dr. Tyler Smith had supported the view that commencement of labor was a function of the ovaries. This view was now rendered almost untenable by Mr. Thornton's case. He had no doubt whatever that the ovaries were indissolubly connected with menstruation.

Dennis on Laparotomy in the Treatment of Penetrating Wounds and Visceral Injuries of the Abdomen.—The conclusion at which I have arrived from a study of those cases which have occurred to me recently, together with many others during the past few years, and also from those reported by other surgeons, are these:

First. That penetrating stab wounds of the abdomen are less fatal than penetrating gunshot wounds, but that the former are fatal in too great numbers to content us with the older methods of treatment.

Second. That if the stab wound had injured the intestine or any abdominal organ, laparotomy is indicated. That it may be indicated also in cases where the gut is not penetrated, but where the gut may become twisted as a result of the stab wound.

Third. That in a penetrating stab wound regarding which doubt exists, the diagnosis should be made certain at once, in order to pursue a proper line of treatment. The indications for laparotomy should be extended also to injuries of any organs within the abdomen.

Fourth. That laparotomy offers no great additional danger to the patient, if properly performed under the strictest antiseptic precautions.

Fifth. That while the number of exploratory laparotomies in stab wounds of the abdomen afford insufficient data upon which to establish any fixed rule of practice, the same principle which is recognized in the performance or laparotomy for gun shot wounds of the abdomen is also applicable to penetrating stab wounds.

Sixth. That the enlargement of the original wound for an examination of the peritoneal cavity will not enable the surgeon to exclude in all cases fecal extravasation, perforation, vovulus, or hæmorrhage. These may all exist, and no evidence of their presence be manifest upon inspection through a small opening. My own experience accords with that of Prof. Weir, that enlarging the wound may or may not offer the essential knowledge.

Seventh. The size, shape, character, and velocity of the bullet, the attitude of the patient, the kind of weapon used to produce a stab wound, seem to me to influence the question of laparotomy. Any and all of these injuries are likely to produce perforation, and if there is any value in abdominal section, it should be promptly performed, irrespective of the facts connected with the penetrating abdominal wounds.

Eighth. It is impossible to have a fatal hæmorrhage from the large venous trunks in the abdomen, and this hæmorrhage not be discovered until the cavity is about to be closed, when an attempt is made to sponge out the bottom of the peritoneal cavity. This has occurred to me in two cases, in one of which I have closed seven openings, and in the other I had examined the viscera in the cavity. The hæmorrhage was checked at the time of the opening, and was not apparent until the close of the operation.

Ninth. That the sutures, if properly applied, will close the perforation in every case, no matter how lacerated the wounds are. The sutures will close the wound in case of resection of the gut, so that no leakage will occur if water is forced through the sutured intestine.

Tenth. The success of laparotomy is to be attained where every arrangement is complete and perfect. Every thing depends upon the preparation which is made for this operation, and the antiseptic conditions under which it is performed. The shock, the perforations, the resections of injured parts of the canal, and the after-treatment, are all important steps in this great operation; but the one obstacle yet to be overcome in the management of these cases is the control of the hæmorrhage from large venous trunks, and until this object is accomplished, the science of surgery in this operation cannot be said to have arrived at a state of perfection.

In the present unsettled state of opinion, it would seem best not to perform this operation in medico-legal cases without the full sanction and support of a consultation. The courts of law have recently agitated the question of the propriety and the justifiability of this measure in penetrating wounds, and the legal profession have already upon several occasions, to my personal knowledge, found refuge in this operation to defend a criminal on trial for murder. —*Med. News*, March 6, 1886.

Notice of Removal—Dr. T. Gaillard Thomas has removed from 294 Fith Ave., N. Y. to 600 Madison Ave., between 57th and 58th Sts.

Some Points in the Practice of Artificial Respiration in Cases of Stillbirth and of Apparent Death after Tracheotomy.—Mr. Francis Henry Champney's, in an article in the April number of *The American Journal of the Medical Sciences*, in which this whole subject is carefully considered, thus sums up the treatment:

Never hurry, it is a question of seconds, and success depends upon a fine exercise of the judgment Make a good diagnosis, first as to life or death, secondly as to the stage of asphyxia (if life is not extinct). If the child is macerated, it is obviously dead and past hope. If the heart beats, ever so slowly and feebly, it is not dead. If the heart is not beating, death is not certain, unless it can be proved to be inactive for some time. If the child is livid and not flabby, it will probably come around, wipe out its mouth and pharynx, and rub it with a soft cloth down the spine, press gently on the cardiac region. If this produces no effect, inflate the lungs by the mouth, and then by Silvester's method. If air enters the lungs, well and good; if not, try Shultze's method, or insert a catheter. On the first sign of muscular action, plunge the child into cold water, or into alternate hot and cold baths. Vary the treatment between occasional inflation of the lungs, artificial respiration, pressure over the cardiac region, baths, irritation down the spine according to the judgment, remembering what may be expected of each method, and that no one will suffice for all cases. Watch for signs of resuscitation, namely, improvement in the color, in movements, in cardiac pulsations, as described above. Never be content until the child breathes regularly, and appears to be continually improving.

Boracic Acid in Diabetes Mellitus.—Mr. F. A. Monckton reports in the *Australasian Gazette* (October, 1885) a case of a boy, aged 14, suffering from diabetes mellitus, with all the symptoms in an aggraved form, who was apparently cured by the use of boracic acid in seven-grain doses three times daily. At first

there were no stringent dietary regulations, and even in the later part of the treatment only sugar, potatoes, and oatmeal were forbidden. Bread was eaten at the meals in the ordinary way. He gradually gained in weight, his health improved, and the sugar disappeared from the urine.—*Therapeutic Gazette*, January 15, 1886.

Medical Items.

The North Carolina State Medical Society will meet at Newbern on May, 19th.

The Mississippi State Medical Association will meet at Jackson, on April 21st.

Jefferson Medical College at its recent commencement conferred the degree of M.D. upon 223 graduates.

Queen Victoria has recently conferred the honor of knighthood upon Professor William Turner, Professor of Anatomy at the University of Edinburgh.

It is stated that suits for alleged malpractice against physicians have become so frequent in Chicago, that the profession in that city will organize a physician's protective association.

At a recent meeting of the Faculty of Bellevue Hospital Medical College Dr. E. G. Janeway was transferred to the chair of principles and practice of medicine and clinical medicine, made vacant by the death of Prof. Austin Flint, Sr.

The Commissioners of Charities and Correction of Bellevue Hospital, on the recommendation of the medical board, have decided to erect a mural monument to Dr. Austin Flint in the hospital.

It will be remembered that the late Dr. Austin Flint was selected by the British Medical Association to deliver the address in medicine before the next meeting of that body. In consequence of Dr. Flint's death, Dr. J. S. Billings has been selected to represent American medicine before the British Association.

The *Lancet* says: "We have reason to believe that the eminent pathologists, Sir James Paget, Professor Burdon Sanderson, and Dr. Lauder Brunton, have, together with Sir. H. Roscoe, who initiated the matter, consented to serve on the commission to inquire into M. Pasteur's method of inoculation for hydrophobia; and that the Government intended to seek in addition the services of a few distinguished physicians, including Sir Wm. Jenner."

At a stated meeting of of the Medical Association, District of Columbia, held on the 6th inst., the following officers were elected for the ensuing year: President, Dr. J. M. Toner; first vice-president, Dr. J. W. Bulkley; second vice-president, Dr. George Byrd Harrison; secretary, Dr. Lachlan Tyler; Treasurer, Dr. S. S. Adams.

There are now enrolled, as members of the night medical service of Paris, 608 physicians and 356 midwives, serving from 10 P. M. to 7 A. M. During the year 1885, 7,494 calls were received from a population of 2,226,000 persons. Of these calls, 52 per cent. were to attend women, 32 per cent. to attend men and 16 per cent. to attend children.—*Progres Med.*

The first number of the *Nouvelles Archives d' Obstétrique et de Gynécologie* has appeared. It is published under the direction of Professor Duplay, MM. Charpentier, Guéniot, and Polailon, *agrégés* at the Paris Medical Faculty, Drs. Bernutz, Siredey, Porak, and Doléris. This journal will appear every month, and will contain contributions from foreign gynæcologists.

Dr. E. Martel, surgeon *en chef* at the Hôtel Dieu Hospital, Saint Malo, publishes in the *Gazette des Hôpitaux* an instance of tænia expelled by the mouth. The patient was a maiden lady, aged 86. During five years she had been accustomed to eat raw meat, rubbed into a coarse powder. One day she had a slight attack of indigestion, after having a glass of milk and some red wine; whilst vomiting, she felt something in her mouth, which she quickly removed. It was a tænia about twenty-seven inches long; it was apparently sterile. Ten days later, the patient expelled with a motion a tænia nearly two feet long, by the anus. There were no symptoms indicative of the presence of the parasite. The patient complained of feeling a constant necessity to pass urine, and increased thirst; but this condition was more probably the result of old age and the heat of the weather.—*Br. Med. Jour.*

The *Weekly Medical Review*, of St. Louis, says: "The next meeting of the American Medical Association in this city is not as yet a subject of much enthusiasm, as far as the local profession is concerned. The present chairman of the Committee of Arrangements invited the Association here, mainly on his own responsibility and against the judgment of the St. Louis profession." The *Review* further says there are many reasons why the Association should not come to St. Louis this year, the chief of which seems to be that "many men here devoutly trusted, inasmuch as there was evidence of an impending conflict in the Association, the next meeting would be far removed from their quiet and peaceful labors."

The *Review* states that "but little has yet been done by the profession or the public to prepare for the Association." It asks "that for decency's sake some increased interest may be taken by St. Louis physicians."

Original Articles.

CHOREA.—ETIOLOGY, PATHOLOGY AND TREATMENT.*

BY SPENCER M. FREE, A.M., M.D., OF BALTIMORE.

Were I to present a paper on chorea at all commensurate with the literature, the importance of the subject, and the amount of attention given it by able men, an entire evening would be far too short time for its reading. Hence, to confine myself within a reasonable limit, I shall discuss only the etiology, pathology, and treatment. I shall be compelled, therefore, to omit much that would assist us the better to understand the researches of others, and shall presume largely upon your familiarity with the literature.

The chorea major or epidemic chorea, though very interesting, is not to be a part of our discussion to-night, and you will therefore understand that all I shall say refers to chorea minor, the disease commonly met with in our practice.

Dividing the causes according to the old-fashioned plan of predisposing and exciting, we note as of the first class,

1. *A Neuropathic state.*—Not that chorea itself is transmitted, but that it frequently, and we might say preferably, occurs in families having a history of epilepsy, paralysis, insanity, apoplexy, hysteria, and other neuroses; especially the *functional* neuropathic disorders.

Dr. J. Lewis Smith reports three cases occurring in one family. I have seen two cases in the same family, and one in that of a sister. May not this cause explain to some extent those cases classed under "cause not ascertainable," which in this country includes about twenty per cent. of the cases?

2. *Age.*—The ages from six to fifteen years embrace about seventy per cent. of the cases. Of 546 cases tabulated by Putzel, 437 occurred between five and fifteen years.

Of 82 cases reported by Hammond, 53 were between six and fifteen years. The youngest case seen by Hammond was 19 months. Hillier reports a case at 3 months. I have at present under treatment a child 5 months old which is choreic, if it should not prove to be an idiot. It is improving under arsenic, internally, and the cold pack to the spine, but I am by no means certain that it is not a case of idiocy. In fact, I am strongly inclined to the idea that many cases in infancy diagnosed chorea, are cases of hydrocephalus or idiocy.

A few cases (eight, on good authority) of congenital chorea are reported. In four of them the mothers were very nervous, or experienced severe nervous shock, during the pre-natal condition. The disease is rare in adult life, though Dr. R. T. Wright reports a case of three years' standing in a man 78 years old.

3. *Sex.*—Of 1435 cases tabulated by one author, 1053 were females. J. L. Smith gives the proportion 2.15 female to every 1 male. West found 64 per cent. female. At Bellevue, N. Y., the proportion is 2.4 female to each male. Rufz gives 138:57. Hughes 73:27. Steiner 40:12. A combination of a large number of cases reported by various authors gives a proportion of nearly 3 females to each male. Please note this proportion, as we shall again refer to it.

4. *Season.*—It would seem from scanty statistics that more cases occur in winter than in summer. According to Hammond, in the proportion of 54 during the winter months to 28 during the summer.

5. *Bad Hygiene* is named as a predisposing cause of this, as of all other ailments with which we are acquainted, excepting probably a few cases of fracture by direct violence, arterial section (by mistake) during operations, and an occasional suicide.

It is time we, as intelligent investigators, ceased to hide our ignorances of etiology behind "bad hygiene," as we do those of diagnosis behind "rheumatism" and eczema." While "bad hygiene" and "dirt" are factors, and at times important ones in the causation of disease, they are entirely over-estimated by many observers, and are blamed for things for

*Read before the Baltimore Medical and Surgical Society, February 25, 1886.

which they are in no way responsible.

6. *Exhaustive Diseases.*—I need scarcely name anæmia from its many causes, as well as all forms of disease producing great waste and prostration. These are self-evident causes of many neuropathic disorders.

Exciting Causes.—1. *Intestinal Irritation* from lumbricoides or tæni. Ogle reports such a case, and Leidy, in a recent paper, calls attention to the fact that "in children they give rise to epileptic fits and chorea."

2. *Imitation.*—This is usually considered to refer to the epidemic form, but a few cases are reported of the chorea minor caused in this way.

3. *Pregnancy.*—Quite a number of such cases are recorded. Dr. Robert Barnes alone reports 56 cases. I met with a severe case in a woman pregnant for the first time, when advanced three months. She was relieved with arsenic, and four months after miscarried, giving birth to a living fœtus about seven months old, and another about four. Might the chorea be in any way related to the second fœtation? It occurred at about the same time.

4 *Emotions* play a very important part in the causation of this affection. All authors accord them a prominent place and hundreds of cases are reported. One of the most unique is that of Mr. Henry Day. He was one day passing along a road when a boy frightened by being called to, fell from an apple tree. He was not hurt, having struck on the front of the body, but immediately chorea (bilateral) developed, which lasted nearly a month.

Hammond reports 27 of his 82 cases due to fright, anxiety, &c. Putzel, of 92 cases, 25 are due to fright, 8 to excitement.

Of 100 cases at Guy's Hospital, 31 were emotional. The emotions, while not producing as many cases as all other causes combined, produce more than any other single cause.

5. *Bad, Indulgent Education.*

6. *Other Diseases*—such as toothache, nasal catarrh, etc.

7. *Masturbation.*—This is given by all authors as one of the important causes. I very much doubt its importance as a causative agent in many other nervous diseases as well as in this.

I readily see that if indulged in to *excess* it may produce exhaustion, and hence be a causative agent. Very few cases can be found recorded by good authorities.

I am persuaded that the practice is a very common one, much more so than we are disposed to believe, among both male and female children, and if it is an important causative agent we ought to have more cases. Further, I have never been able to understand why masturbation should be any more the cause of numerous neuropathic ailments than is sexual intercourse. I think there is an over-estimation of this element in the causation of disease.

Please do not understand that I favor masturbation, or enter a plea in its behalf. I simply wish to put the blame where it properly belongs. Both copulation and masturbation, in excess, produce exhaustion and then disease. Neither in moderation produce any physical injury. The moral side of the question is not pertinent at present.

8 *Lesions of the Brain and Spinal Cord.*—Prof. Post reported a case from a stroke on the head by a billet of wood. Putzel, 5 cases from blows on the head.

Sir Benj. Brodie, one caused by a tumor of the pineal gland.

Broadbent, one from tumor of the spinal cord.

Chambers, one from tubercles in the cord.

Romberg, one from pressure on the medulla by a large odontoid process.

I could multiply cases, but it is useless. On account of this, arose the two names idiopathic and symptomatic chorea. Some able men teach that both classes exist, others that all chorea is symptomatic, while others believe that only one kind, the idiopathic, can be properly recognized.

Of those believing the disease purely symptomatic is H. C. Wood, to whose views I shall refer under the next part of my subject—pathology.

9. *Embolism.*—In the discussion of this, and the last cause which I shall

name (Rheumatism) it will be very difficult, I fear, to separate the etiology and pathology, and frequently they will be discussed together.

Minute particles, the result of vegetations from the valves of the heart usually, or from some other source of emboli, get into the capillaries of the corpora striata or the cord and set up such disturbance that chorea results. This theory has numerous warm supporters.

Dr. Wier Mitchell has found that adults who have recovered from hemiplegia often have chorea afterwards, and that the younger they are the more liable are they to the disease.

Dr. Angel Money, in a paper before the Medical and Chirurgical Society of London, in May, 1885, claims to have produced in dogs, rabbits, guinea-pigs and cats, movements similar to those of chorea. His plan was to produce capillary embolism by injections of arrow-root, starch granules, or carmine, into the arterial circulation. The common carotid artery was most frequently used. He was not successful in the monkey.

Cobbold has noted irregular movements (resembling chorea) in the horse, due to worms in the arterial circulation.

Of those regarding embolism as a cause are Broadbent, Hughlings Jackson, Ogle, Tuckwell, Kirkes, Barnes, Russell, Mitchell, and Wood.

Men of equal prominence hold the opposite view, and the argument on that side is as well and completely set forth in J. Lewis Smith's last edition of his *Diseases of Children* as anywhere in our language.

10. *Rheumatism.*—Of all the causes this is the one of probably greatest interest and has provoked much study and dispute. One writer says that "simple chorea is frequently observed as a complication or a sequence or even an antecedent of acute articular rheumatism".

Of 1436 cases collected from fourteen observers, 273 had history of rheumatism.

Dr. Sturges in 202 cases recently reported 19 per cent, with rheumatic history.

In Ziemssen's observations, 1 to 5 had it.

Steiner reports 252 cases of multiple arthritis of which four had chorea.

There is evidently some relation between the two diseases, not clearly understood.

Rheumatism is comparatively rare among children, common in adults; while the opposite is true of chorea.

In Sée's report of 11,500 cases, 139 had rheumatism; 61 with chorea, 48 without.

Rheumatism is more frequent in boys, chorea in girls. You will recall the proportion of the latter, mentioned under the subject of sex, viz: nearly 3 to 1. In the matter of rheumatism the proportion could be reversed and accord with the facts. From this our argument would lead us to conclude that the same agency produces in a boy rheumatism, in a girl chorea.

Roger after a long series of investigations concludes that "acute rheumatism of the joints, affections of the heart (endo and peri-carditis), and chorea are but three manifestions of the same diathesis."

Wood in a very careful article on the subject regards chorea, like paralysis, merely a symptom

Rosenstein says: "my own observations confirm the frequency with which mitral affections are complicated by chorea, especially in very young children."

In 71 cases reported by Roger, 47 had endo-carditis, 10 peri-carditis. While we cannot regard his methods of examination sufficiently accurate for diagnosing inflammatory trouble, there was in each of the 66 cases a systolic murmur. Some were probably anæmic, but it is equally fair to suppose that some were of inflammatory origin.

Of sixteen examined after death by Ogle, ten had fibrinous deposits on the valvular endocardium.

To not occupy your time longer with citation of cases and authors, is there not good reason to regard both rheumatism and chorea, as neuropathic affections due to similar or the same lesions?

I think I may safely state that recent investigators believe this form of rheumatism different from the true acute articular variety. There is no doubt much

clinical difference. In this form there is very little redness or swelling of the joints, little pain, and little elevation of temperature. Hence this is being spoken of now as a neuropathic arthritis. Furthermore the heart murmurs cannot be due to serious inflammatory processes, else they would not end in perfect recovery as is usually the case; nor can they all be due to anæmia, for a large percentage of cases are not anæmic. It seems therefore a reasonable conclusion, at least one worthy of examination, that the views expressed by Roger as to the neuropathic origin are correct.

We shall now pass to the consideration of the pathology, which on account of the meager knowledge, will not require much time for its examination.

Hughes, of London, in fourteen cases found the brain healthy in four cases, congested in three, soft in part or entirely in six. The cord healthy in three, conjested in two, soft opposite the fourth and fifth vertebræ in twelve. In sixteen cases at St. George's Hospital congestion of brain or cord were found in six cases. There are so many different conclusions arrived at by the various investigators, and so many cases that show no pathological signs that one is almost inclined to say it has no pathology.

Rokitansky, who has studied with great care a few cases, found interstitial growths of connective tissue in the central nervous system.

Steiner confirms this opinion and adds the finding of an effusion of blood and a serous exudation in the spinal canal.

Meynert found anatomical changes in the gray substance of the central ganglia, extending thence to the cortex of the brain. These changes "consisted in processes of division in the nuclei of the nerve-cells, interstitial growth of nuclei, and hyaline swelling of nerve-cells with molecular decay of protoplasm." He found in the cord "swelling of the star-shaped interstitial connective tissue corpuscles."

I referred before to the views of embolism held by Kirkes, Jackson, etc.

Dickinson believes that the disease is due to a wide-spread hyperæmia of the nervous system due either to a rheumatic condition or various forms of irritation, mental and reflex.

Sturges holds that it is a functional disease arising in most cases from some strong nervous impression.

Broadbent thinks the processes in chorea merely weaken the force of the nervous apparatus without destroying its structure. He calls it "delerium of the sensori-motor ganglia of the brain."

Dr. Haydon, of Dublin, "believes the attack begins with a vaso-motor paresis, the consequence of a profound emotional impression, and that the essential symptoms are due to defective polarity or dynamic instability of the motor-nerve tracts, both intra-cranial and spinal."

One of the latest opinions is that of Dr. H. C. Wood, of Philadelphia, who regards it "a diseased condition of the ganglionic structures of the cerebro-spinal axis, which abnormal state may exist without alteration of structure sufficient to be determined by the microscope, or may go on until it is accompanied with marked structural lesions. Further, this condition must be looked upon as one of lowered tone, and it must be allowed that it may be produced by various causes, but is little prone to occur in persons of robust nervous system."

I have presented the ablest and most plausible views, and yet doubt if any of them explain the condition. Indeed I question many times whether it has any definite pathology.

It would seem that there is some peculiar condition of the nervous system which we do not understand, that will under proper conditions produce disturbance of serous membranes, preferably those of the heart, joints, or cerebro-spinal canal, giving rise in the first case to an endo or peri-carditis, in the second to an arthritis, and in the third to a disturbance of the muscular system known as chorea.

Why it should produce at one time one of these, and at another time another, or more than one in the same individual; or why in the male the joints should preferably be affected and in the female the cerebro-spinal canal we do not understand, probably never shall.

Treatment.—Drugs have been em-

ployed extensively as to number and dosage. With few exceptions they are valueless.

The first to be recommended is as far as possible fresh air, out-door exercise, avoidance of excitement, proper bathing, plain and nourishing food. If the case is severe rest in bed may be of advantage.

If a cause is discoverable, as worms, decayed teeth, nasal catarrh, etc., remove it.

Without a careful search we have come upon thirty-nine forms of treatment.

Strychnia has its warm advocates. Trousseau probably is its best exponent. He uses a solution of the sulphate. He gives it in a dose of $\frac{3}{100}$ of a grain t. i. d. gradually increasing the amount to 1 gr. per day. He cautions concerning the great danger, and enjoins care and watchfulness.

West and Bouchut oppose its use on account of the danger, as a number of deaths have been produced by it.

In all anæmic cases tonics are called for. Iron in some form is preferred by nearly all writers. Radcliff uses the iodide, J. Lewis Smith the ammonio-citrate. The mur. tinct. is generally used. The emulsion of cod-liver oil with the hypophosphites of lime and soda has been used with good effect.

Dr. Young, of Philadelphia, prefers cimicifuga.

Dr. West, sulphate of zinc.

Drs. Steiner and Hufland, oxide of zinc.

Dr. Wier Mitchell, salicylate of soda especially in cases of rheumatic diathesis.

Dr. J. H. Carstens, propylamine.

Dr. Goodheart, rest.

Drs. C. L. Dana, Mills, Webber, Rockwell and Beard, galvanization of brain.

Drs. Baunis and Burnheim, regard hypnotism a specific. Only a few seances are necessary.

Applications of cold to the spine by means of the wet pack, a jet of cold water, or the ether spray have been used quite extensively and with good effect. Some advocate the cold bath, or cold shower bath. I have used the cold wet pack in several cases with excellent results. I follow the packing by rubbing with olive oil. These cold applications are used in conjunction with internal medication.

The one remedy which is the main reliance of the great majority of practitioners is arsenic. It is usually given in the form of Fowler's solution, in a gradually increasing dose. Of those who rely chiefly upon it are Smith (J. Lewis) Leesse, Rayer, Martin, Gregory, Latter, Babington, Hughes, Begbie, Romberg, Dieudonne, Barthez, Aran, Edes, Hammond and Seguin.

Dr. Hammond strongly advocates its use hypodermically.

Dr Gellé says that it fails in nervous and sanguine patients.

Dr. Romberg and Bourguignon agree with him.

In a series of cases reported by Dr. Chapin, of N. Y., treated entirely by arsenic, in which he compares his results with those obtained by Drs. Gray and Tuckwell, who used the expectant plan, the result was twelve days in favor of the arsenic treatment.

Some few are doubtful as to the value of any treatment, but the results obtained show a shortening of the diseases by judicious management and medication.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MARCH 19, 1886.

PARALYSIS OF THE ARM FOLLOWING INJURY.

Dr. W. B. Platt presented a patient suffering from paralysis of the muscles of the left arm. The man has a history of a fall from an elevation of 12 feet, striking upon the left anterior side of the head and remaining insensible for ten minutes, after which he regained consciousness and walked without assistance to his home, a distance of about one mile. The paralysis is at present confined to the abductors of the arm, the muscles of the forearm beyond a little stiffening from want of use, are not affected.

On the surface of the man's body is a copper-colored eruption,strongly suggesting a syphilitic infection, although the patient firmly denies ever having had a chancre. Behind one of his ears is an enlarged gland.

His paralyzed muscles give almost no response to the strongest faradic current.

There has been neither pain nor swelling at the shoulder at any time. The paralyzed muscles are slightly atrophied as may be seen by comparing them with those of the opposite side.

On the left side of the head, anteriorly, there is a depressed cicatrix.

Dr. Platt exhibits this case for the purpose of getting the opinion of the members present whether the paralysis is of a syphilitic origin, or whether it is due to an injury to one of the convolutions of the brain underlaying the point of injury to the head.

Dr. E. G. Waters. What is the patient's occupation? Has he ever been exposed to the poisonous influence of lead?

Dr. Platt. By occupation the man is a carpenter. He has not, to the best of my knowledge, been exposed to the toxic action of lead.

Dr. Waters thinks the paralysis due rather to a blow on the shoulder than to the fall on head. If resulting from the head injury, it would be on the opposite side.

He had treated a man who fell from the top of a car, striking on his shoulder, and resulting in complete paralysis of the right deltoid muscle. Three weeks from the time of injury, the man's general condition being good, a blister was appled over the paralyzed muscle. After the epidermis was removed the surface was sprinkled with a small amount of powdered strychnia. After four or five weeks of this treatment the muscle regained its normal tone and recovery was complete.

Dr. John Chambers. Did Dr. Platt's patient ever complain of a pain in the shoulders?

Dr. Platt, he never complained either of pain or swelling at the shoulder.

Dr. Joseph T. Smith. Has any improvement been observed as a result of treatment?

Dr. Platt thinks he has noticed a very slight improvement in the muscles since the faradic current has been used.

For a few days the man was on the iodide of potassium, but lately has been taking the biniodide of mercury.

His individual opinion regarding the condition is, that the man has sustained an injury to one of the cerebral convolutions, and being constitutionally tainted by syphilis the injury has,in consequence, become chronic and given rise to this paralysis, whereas, such an injury to a convolution of the brain in a healthy individual would have passed away without giving rise to any permanent trouble. As to the paralysis occurring on the same side as the head injury,he thinks this may be accounted for by non descussation of the fibres coming from this convolution Such anomales are known to occur.

Dr. J. H. Branham dont believe that non decussation occurs with sufficient frequency to justify us in using it as a factor in diagnosis.

Dr. Platt only suggested its possibility, he did not offer it as his opinion.

Dr. John Chambers thinks the paralysis peripheral and due to a neuritis. The difficulty would be extreme in locating the centre that might be involved in causing such a paralysis.

Dr. G. H. Rohé. Does Dr. Platt exhibit this eruption as a syphilitic one?

Dr. Platt takes it to be syphlitic although the man firmly denies any primary infection.

Dr. Rohé thinks the brain lesion has appeared rather too early to be syphilitic. It is remarkable that brain and skin lesions should appear at the same time.

Dr. Platt, in closing the discussion, said, as to neuritis, he had failed to get any history or find any local evidence of injury that would suffice to cause a neuritis. As to the early appearance of cerebral lesions in syphilis, much has been done on the subject in Germany, and it is found that they occur with much greater frequency than was at first supposed.

Dr. W. J. Jones next read a paper on a case of

ENCAPSULATED PELVIC PERITONITIS.

Dr. W. Pawson Chunn. Was the

woman examined in knee-chest or in Sims' position with Sims' speculum to see if any opening or fluctuation could be found?

Dr. Jones. She was, but neither any opening nor fluctuation was present. Some slight induration was felt on left side.

Dr. N. G. Keirle asked if the ulcer found in the ileum might not have occurred primarily and caused a slight perforation with a secondary peritonitis.

Dr. W. T. Councilman said the ulcers in the ileum were of too recent origin to have been under the circumstances, anything but secondary. Without doubt they were secondary to the tubercular peritonitis. It is his opinion that the infection took place previously in the lungs, spreading thence to the pleura, and peritoneum and finally to the intestinal tract.

Dr. William Pawson Chunn exhibited specimen and related a successful case of

OVARIOTOMY WITH SUPRA-VAGINAL AMPUTATION OF THE UTERUS IN A NEGRESS.*

DISCUSSION.

Dr. J. Edwin Michael. Had Dr. Chunn added *endurance*, to his remarks concerning the woman's courage in refusing to take an anæsthetic, it would not have been amiss. He had had the pleasure to witness the operation reported by Dr. Chunn, and congratulated him on the success of the case. He was compelled, however, to differ with Dr. Chunn in regard to the necessity of performing hysterectomy. An examination of the specimen will show that the uterus is free from adhesions to the tumor on both its anterior and posterior surfaces and is only connected with it by means of adhesions of the broad ligament. The tumor, in other words, having its proper pedicle on one side, had become adherent to the broad ligament on the other side, and these adhesions could have been ligated and cut and the tumor removed as is usual in such cases with less danger to the life of the patient than that in which she was exposed in the operation done.

Dr. W. B. Platt thought the true character of the clear urine like fluid referred to by Dr. Chunn could have been positively made out had it been subjected to chemical and microscopical examination.

Dr. W. E. Mosely. By examination of the specimen presented, anyone would without hesitation agree with Dr. Michael, that the tumor could have been removed without taking out the uterus.

Dr. Chunn, in closing the discussion, said that in spite of such formidable opposition he still held his original opinion that it was impossible to remove the tumor and not the uterus. Dr. Michael probably differed with him because the relations between this tumor and the sac were very different after removal from what they were in situ. This was simply because the sac and uterus were amputated obliquely, and hence the specimen as shown does not exhibit the full and true relations of the parts.

He did not remove the other ovary because he could not find it. He referred to a case in which such an omission had been made and in which, in consequence, there was an extra-uterine pregnancy through the remnant of the cervical canal.

GUNSHOT WOUND, DIVERTICULA OF TRACHEA AND ŒSOPHAGUS.

Dr. W. T. Councilman exhibited specimens from a very interesting case of gunshot wound. Also two specimens of diverticula, the one a diverticulum of the œsophagus, the other a diverticulum of trachea. The one in the œsophagus was near the pharynx. It was of the ordinary pressure variety—that is, there is a want of development of the muscular tissue at the point, and in consequence, pressure brought to bear causes a sacculation of the mucous membrane. There was a grain of corn in this sac. The one in the trachea occurred on its anterior surface a little way above the bifurcation. It is difficult to classify it as a traction diverticulum because there was no evidence of any adhesions ever having been contracted.

Dr. E. G. Waters thinks Dr. Councilman's theory respecting the force of the explosion having taken place beneath the skin, a correct one.

*MARYLAND MEDICAL JOURNAL of March 28, 1886.

He takes it, it was the result of the delayed explosion of an excess of powder used in loading the pistol. Persons, unaccustomed to the use of firearms, make a common mistake of employing too great a charge of powder and in consequence the excess is not exploded until after it leaves the weapon, or if not projected against a resisting substance, may not be ignited at all.

Dr. Waters has proved this, to his mind, by experiments he has made by firing charges of powder over white surfaces; such as snow or sheets, spread upon the ground.

Dr. John Hemmeter thought the rupture of the liver might have resulted from the sudden admission of air into the thorax.

Dr. F. R. Nordman related a

CASE OF TRICHINOSIS

and showed microscopic and macroscopic specimens. The condition was not diagnosed ante-mortem.

Dr. N. G. Keirle thinks trichinosis may be acute or chronic. He has observed a dysenteric condition of the bowels coexistant with trichinosis. Thinks this dysentery of trichinous origin.

The case reported by Dr. Nordman, he takes to be a chronic one, and in his opinion, the evidence of a former dysentery, as was seen in this case, was one of the acute lesions.

The first case that he saw was the one recently reported as occurring at the City Hospital—the clinical diagnosis was suggested by Dr. Bressler and was then worked up by Prof. Bevan.

Dr. G. H. Rohé thinks many of the old rebellious dyenteries may be of trichinous origin.

Dr. L. McLane Tiffany, don't think old dysentery a recognized symptom of trichinosis.

ABNORMALTIES OF THE AORTA.

Dr. Randolph Winslow exhibited a rare specimen of anomalous condition of the great trunks arising from the arch of the aorta, as well as of the aorta itself. The specimen was taken from the body of negro man, which race seems to be particularly prone to anatomical variations. The aorta passed between the œsophagus and spinal column, and then passed down in the regular manner. There were four trunks given off from the arch as follows, 1st, left carotid; 2d, right carotid; 3d, right subclavian; 4th, left subclavian. The left carotid passed obliquely in front of the trachea to reach the left side, thus enclosing this tube in an arterial ring, which would be in danger of injury during tracheotomy.

Dr. Winslow said the aorta was liable to a variation in the number of the trunks arising from the arch, which sometimes consisted in an increase, sometimes in a diminution. The present specimen was one in which there was both an increase and transposition of these branches. The increase to four trunks might be produced by simple fissure of the innominate, or by an abnormal left vertebral, or by an abnormal right thyroid, or thyrœdea ima; probably the most frequent increase was the origin of the left vertebral from the arch. When the innominate was absent it was frequently noted that the right subclavian arose from the extreme left arch below the left subclavian, and then passed behind the œsophagus to reach the right side. The number of trunks arising from the arch might be diminished in various ways, the most frequent being the origin of the left carotid from the innominate, as in a specimen which was exhibited by the doctor.

Dr. H. Clinton McSherry presented a specimen of

PYRIDIN.

It was first described by Anderson in 1851; it is obtained from oils which are the result of distillation of bones. He has used it successfully in a case of asthma occurring in a very neurotic woman. The method of administering it, is by the inhalation of its vapors. About ʒ ii may be poured into a saucer and allowed to stand uncovered for about one hour and a half in a closed room in which the patient is confined. This may be repeated three times a day. The relief is, as a rule, marked.

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BALTIMORE, APRIL 24, 1886.

Editorial.

"THE WEAR AND TEAR OF MODERN LIFE."—The recent sudden illness of the Secretary of the Treasury and the present ill-health of several other members President Cleveland's Cabinet have called attention to the fact that many public men in high official position are being subjected to an amount of over-work and nervous tension which even the strongest constitutions cannot endure. What is true in this respect of our public officers is applicable to the great mass of professional and business men in our large centres of population. It is a fact, we believe, that the majority of lawyers, clergymen, physicians, bankers, and merchants are living at a rate of speed which must sooner or later result in the premature breakdown of mental and physical forces. The high tension, which is peculiar to metropolitan life, subjects our prominent working citizens to pressure, worry and anxiety unknown to former generations. It seems next to impossible for a man to occupy a position of great responsibility or of trust which does not in some way impose on him greater labor and pressure than is conducive to even moderate health. The break-neck speed at which the modern locomotive travels is scarcely surpassed by the hurry and rush which characterize the present march of human progress. The modern struggle for position and for wealth calls for the expenditure of an enormous vital energy. This expenditure of mental and physical force seems to be an inevitable result of modern civilization. It seems as impossible to put a check on it as it is to chain the lightning flash. The medical profession, the press, the pulpit, and the essayist may discuss its importance and utter their warnings, but despite the word in season and out of season, the line upon line, the pressure moves along with relentless rush.

As in the deadly combat the depleted lines are filled up by fresh recruits, so in this modern struggle for place or wealth numerous subjects are ever ready to fill up the opening gaps. For every vacant Cabinet portfolio there are hundreds willing to accept its labors and responsibilities, nay, even its legacy of a broken constitution. It seems then useless to discuss the subject of wear and tear of modern life from a standpoint which would place an embargo upon physical and mental hard work. There can be no limit placed upon this expenditure of vital forces save the capacity of the individual to endure or to recuperate. Safety from the influence of wear and tear must be sought in conditions which surround the hard worker. Modify these conditions so as to bring the hard-worked individual within the limit of physiological surroundings and the hard-worked muscular system or the hard-worked brain will not seriously suffer. It is not so much the hard work which is breaking down constitutions as the unhealthful manner in which this work is done; the over-crowing, worrying, and the unnecessary expenditure of vital force as the result of over-pressure and of worry. It is the jar and friction which wear and grind out the physical and mental mechanism of the human system. There is a vast difference in the manner in which individuals work. A few men, like well-oiled machines silently perform the duties imposed upon them. If they suffer from wear and tear it is not seen. In other words they so adjust themselves to their work that it is accomplished without waste of force or energy. This is a fortunate gift; the man thus endowed is equipped for a long and useful career. The safety then

for the modern hardworker is to eliminate from his work those elements of worry and anxiety which grind out his tissues by friction rather than by activity of function. With hard work there should be associated proper recreation—not an absolute idleness or inactivity, but a change of occupation and of interest, a diversion of exercise, a healthful rest of one set of tired organs and the use of those which have been in abeyance of function. The brain-worker will find health and strength in out door exercise, in horseback riding, in rowing or batting, whilst the man with exhausted muscles or irritated nerves should seek to rest this tire of muscle and nerve by reading, by amusements or by social festivities. Let each hard-worker learn how to rest his mind and body and the wear and tear of modern life will not oppress him. Equally important to the adoption of a system of recreation or of rest is the necessity of attending to the food we eat, the air we breath and the clothes we wear. Hard-workers should eat with care the most wholesome and nutritious food at proper hours and in a proper way. The habit of irregular eating and lunching, of swallowing without masticating, and of taking no rest after heavy meals, is as much to be condemned as any vice of modern living. It most surely lays the foundation for defective nutrition which has its culmination in tear and wear of tissue. With proper regard for pure air and healthful clothing the hygienic conditions of hard work are greatly favored. It is by observing the main facts here presented that the hard-worker may accomplish his manifold duties with comparative ease and safety. The man who wisely uses his time, who adjusts himself to the nature of his environments, who seeks rest and recreation in healthful and inviting employment will most likely receive accessions of vigor from his labor rather than suffer from the wear and tear of his surroundings.

Epispadias in the Female.—Epispadias in the male is a rare malformation, being much less frequently found than the opposite condition of hypospadias; but epispadias in the female is one of the rarest malformations of the genito-urinary apparatus. Owing to the shortness of the female urethra and the small size of the clitoris, the condition when present differs materially from the well-marked affection of the male organ, still there can be no doubt that an analogous deformity does occur in a few very rare cases. A case of urethral malformation in a female child came under the notice of the writer some time since, which, although at that time he had neither seen nor heard of a case of epispadias in the female, seemed to belong to that category, and was so recorded at the time in his note-book. The details of the case are as follows:

A white female child, two years of age, was brought to the writer in the summer of 1884, suffering from constant dribbling of the urine. Upon inspecting the genitals, the vagina was found to be normal, and partially occluded by a hymen, which had not only a central opening, but an extra slit. The bulk of the urethra was present, but the whole vestibule was absent, and the orifice of the urethra reached to the pubes. The vulva was unduly patent, the labia majora not united above, the glans clitoridis on the left side, and the nymphæ entirely separated from each other. The urethral opening is extremely patulous, sufficiently so to admit the introduction of a finger, and through this orifice the bladder-wall projects, the mucous membrane of which is very red, is partly covered with false membrane and bleeds very easily. There is also prolapse of the rectum, and great tenesmus of both bladder and rectum. The child suffers pain, and is wretched from the complete incontinence of urine. There was no separation of the pubic bones, nor exstrophy of the bladder. The condition was considered to be analogous to epispadias in the male. The mother did not bring the child to the clinic again, but subsequently it was seen by Prof. W. D. Booker during his service at the Thomas Wilson Sanitarium.

In the *Centralblatt für Chirurgie*, 1882, No. 15, p. 257, will be found the report of a "Case of Epispadias in the

female," by Dr. R. Frommel. He says this is the fifth case of this nature, others having been reported by Rosser, Gosselin, Klinwæchter and Möricke. Dr. Frommel's case was that of a woman twenty-six years of age, who had suffered from prolapsus uteri for two years, following confinement. In the middle of the pubis there was a trough-shaped furrow, not covered with hair, extending between the well-developed labiæ, which did not come together above. The clitoris was divided into two equal halves. The front wall of the urethra was absent except for three-fourths of a centimetre.

In the position of the posterior wall there was considerable swelling. The pelvis was normal and the symphysis closed. The urine can be contained at the longest only ten minutes. In view of the discomfort of the patient an operation was performed by Professor Schrœder. The furrow was freshened up to the remains of the clitoris, and the two sides of the freshened triangle were united with wire sutures. The result was satisfactory, union occurred, and the patient was subsequently able to retain her urine for three or four hours. In view of the rarity of these malformations of the female urethra, we have thought it worth while to bring these cases to the notice of our readers.

Miscellany.

Obstinate Vomiting Cured by the Stomach-Tube.—Dr. Maere has communicated to the Ghent Medical Society a case in which a young woman who had had some mental shock suffered from such extreme irritability of the stomach that nothing whatever could be retained. The bowels also absolutely refused to act. This obstinate constipation was overcome by faradaism applied by means of an insulating sound with a metallic button introduced into the rectum. Nourishment was given by the bowel. At last, as the patient's condition appeared to be somewhat critical, Dr. Maere, after painting the pharynx with a 1 per cent. solution of cocaine, introduced a Debove's stomach-tube, and poured in a litre of milk and water in equal proportions. This was retained, and afterwards the patient was able to take and retain gradually increasing quantities of liquid nourishment. In a week she was convalescent. The author suggests that the girl's hysterical condition had caused the stomach to contract in the same way as the limbs sometimes do in these cases, and that when this was once forcibly overcome by feeding through the stomach-tube it did not recur. He remarks that painting the pharynx with cocaine is, as has been pointed out by Dr. De la Roche, much more effectual in facilitating the passage of the œsophageal tube than the application of bromide of potassium.—*Lancet, January* 16, 1886.

Morphine Hypodermically, in the Eclampsia of Children.—Dr. M. Leventener, of Constantinople ("Cntbl. f. d. ges. Ther.," xii, 1885), has employed subcutaneous injections of morphine with marked success in a case of eclampsia in a child, four months old, after the usual remedies had been tried and failed. He gave the first hypodermic when the convulsions had already continued for over twenty-four hours, the second was given two hours later, the third six hours, and the fourth ten hours later. In each injection he employed one forty-eighth of a grain of morphine. The first two injections were followed by the cessation of the convulsions for a prolonged period. The hypodermics had to be repeated three times afterward, and the child made a good and rapid recovery.—*N. Y. Medical Journal.*

Hemorrhage Following Uvulotomy Dr. E. Carroll Morgan, of Washington D. C., is engaged in investigating the subject of obstinate hemorrhage following uvulotomy. It is his purpose to collect the interesting unrecorded and recorded examples of this rare accident, and to publish them in the form of a monograph. Dr. Morgan requests such members of the profession as have met with such hemorrhage to answer the following questions and to forward them to his address, 918 E St., N.W., Washington, D. C.

1. State age, sex of patient, etc.
2. For what reason was uvulotomy performed?
3. Was the bleeding primary or secondary?
4. What was the duration and extent of the bleeding?
5. How was the bleeding finally controlled?
6. Was there any assignable cause for the bleeding?
7. What instrument was employed in operating?

Medical Items.

The Legislature of Ohio has recently passed a law establishing a State Board of Health.

The *Medical Record* states that it is fact that there is not a European medical journal, except two, which is not in a quandary over the Congress.

The Legislature of Iowa has recently passed an act to regulate the practice of medicine and surgery in the State of Iowa.

M. Jeunese has left the Faculty of Medicine of Paris sums of 1500 franc and 750 franc for the foundation of prizes in Hygiene and Histology respectively.

The *Atlanta Medical and Surgical Journal* announces the organization of a Polyclinic school at Atlanta, Ga., and speaks very hopefully of the future success of such an institution in Georgia.

The Medical Department of the University of New York, at its recent commencement, held March 6th, conferred the honorary degree of M.D., on Mr. Lawson Tait, of Birmingham, England.

Dr. C. Bohr has been appointed Professor of Physiology in the University of Copenhagen, in place of the late Dr. Panum. Dr. Bohr studied in Ludwig's laboratory at Leipsic, and was several years assistant to Dr. Panum, who specially recommended him as his successor.

Fothergillian Gold Medal has been awarded by the Medical Society (trustee of the fund) to John Strahan, M.D., of Belfast. The successful essay is entitled "The Nature and Varieties of the Fevers prevalent in the United Kingdom," and will be published in the Society's Transactions.

The Archduke Charles Theodore, of Bavaria, who practices medicine, has obtained permission from M. Pasteur to be present at the inoculations in the laboratory of Rue d'Ulm. The Archduchess, who helps her husband in his professional labors, will accompany him as an assistant.

The medical practice act of Illinois has accomplished the following results since it came into existence eight years ago. In 1877 there were 7,400 persons engaged in practice in the State, of whom 3,600 were graduates and 3,800 non-graduates. In 1886 the total number engaged in practice was 6,065, 5,327 being graduates and 739 non-graduates.

The Lancet says "we understand that the sum of £5000 has been entrusted to Sir Andrew Clark by a lady as a donation to medical charities. This sum he has distributed as follow: £2000 to the London Hospital; £1000 to the Medical College attached to that hospital; and £2000 to the Royal Medical Benevolent College. The presentation was preceeded by the payment of a fee of £1500 to Sir Andrew in consideration of his absence from town for five days on a professional visit to this lady in the South of France."

At the annual meeting of the Tennessee State Medical Society, held at Memphis on April 6th and 7th, the following officers were elected for the ensuing year: President, Dr. W. T. Briggs, of Nashville; vice-presidents, Drs. J. W. Penn, of Humboldt, and J. B. W. Martin, of Nashville; secretary, Dr. Ambrose Morrison, of Nashville; treasurer, Dr. Richard Cheatham, of Nashville. The Society adjourned to meet in Nashville on the second Tuesday in April, 1887.

A sanitary convention, the object of which will be to afford an opportunity for an expression of opinion on matters relating to the public health and the discussion of methods looking toward an advancement in the sanitary condition of the Commonwealth, the prevention of sickness and avoidable death, and the improvement of conditions of living will be held in Philadelphia, under the auspices of the State Board of Health, on Wednesday, Thursday, and Friday, May 12, 13, and 14, 1886.

The *Southern Medical Record* published in Atlanta, Ga., is responsible for the following item, "Baltimore publishes four medical journals; has two medical colleges, twenty-two regular professors, and twenty-one regular lecturers, aggregating forty-three teachers. In addition to these, she claims to have four medical societies, etc. Too much physic, we fear." *The Record* is considerably mixed. Baltimore has only *one* medical journal. She has only five medical colleges, whose combined faculties number less than fifty teachers. There are only five local medical societies here, but all have a respectable membership and are in good working condition. Baltimore has an estimated population of over 400,000 and provides a home for over 600 physicians. There may be "too much physic" here, but how about the health of Atlanta with its two colleges, two journals, numerous local societies, population less than 60,000. Too much physic, in Atlanta, we fear.

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